Spire Healthcare Limited

Spire Washington Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Surgery	Good
Outpatients and diagnostic imaging	Good
Termination of pregnancy	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Washington Hospital is part of Spire Healthcare Limited. The hospital provides hospital services to the NHS and other funded patients (insurance and self-pay) predominantly from the Sunderland, Durham and Gateshead areas. The hospital is registered as an acute hospital with 47 beds, and currently there are 36 beds that are operational.

There are 126 staff and 162 consultants working at this hospital. The senior leadership team comprises of the Hospital Director , the Head of Clinical Services, the Surgical Services Manager, the Finance and Commercial Manager and the Business Development Manager. The hospital is supported by experts within the Spire Healthcare Group and externally from local NHS providers.

We inspected the hospital from 5 to 6 August 2015 and undertook an unannounced inspection on 18 August 2015. We inspected this hospital as part of our independent healthcare inspection programme.

Overall, we rated Spire Washington Hospital as good. We rated it good for being safe, effective, caring, responsive and well led in out patient and diagnostic imaging, and termination of pregnancy services. It was rated good for being safe, effective, caring, responsive in surgical services, with well led being rated as outstanding.

Are services safe at this hospital

Every member of staff we spoke with understood the principles of the Duty of Candour. Staff in the areas we inspected stated that they were provided with awareness training through management meetings. We observed an example of duty of candour being instigated in relation to a Never Event. The Head of Clinical Services was the designated hospital lead for safeguarding adults and children . This individual was trained to level 3 in safeguarding children and vulnerable adults. Safeguarding procedures were well managed and staff were aware of the safeguarding policies and principles within the hospital. Staff were knowledgeable about the reporting process for incidents using the electronic hospital incident reporting system. Staff were encouraged to report all incidents and felt that the senior management team demonstrated effective management of all incidents. Lessons were learned across the organisation. Policies and procedures were in place for transfer and escalation of patients to local NHS hospitals when necessary. The hospital had links to local NHS trusts and was part of the local critical care network. The Hospital used a minimum nurse staffing ratio of one registered nurse to five patients during the day and one registered nurse for seven patients overnight, with two registered nurse on duty at all times. A daily assessment of nursing staff requirement was completed to ensure the nursing needs of patients are met throughout the full 24 hour period as recommended by National Institute of Health and Care Excellence (NICE) guidelines. All patients were admitted under the care of a named consultant. Consultants reviewed their patients daily. Out of hours they were available to be contacted by the Resident Medical officer (RMO). The hospital had information accessible to all staff which outlined consultant cover and cross cover arrangements. The hospital's resident doctor and department heads were issued with 'on call' rotas. The hospital employed RMOs who lived on site while they were on duty and worked a seven day rota. There was 24 hour medical cover by the RMOs. There were effective arrangements for handovers between consultants to RMO, RMO to RMO and medical staff to nurses.

Are services effective at this hospital

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. All policies and local procedures were agreed and signed off through the clinical governance committee and medical advisory committee (MAC).

Between April 2014 and March 2015 there were 14 cases of unplanned return to theatre, this was similar to expected for independent acute hospitals. During the same period the proportion of unplanned transfers to another hospital was better than expected. All cases of unplanned transfers were discussed at the clinical governance committee and the MAC. These were also reported through to the organisation's clinical governance meetings. Practising privileges

arrangements and agreements as well as revalidation were robust and effective. Consent to treatment was appropriately obtained . Staff had completed some training with regard to the Mental Capacity Act and Deprivation of Liberty Safeguards. We found varied levels of understanding in relation to this, particularly in the outpatients and diagnostic imaging departments.

Are services caring at this hospital

Senior managers and staff involved and treated patients with compassion, kindness, dignity and respect. The results of the Friends and Family test demonstrated that 98 and 100% of all patients at Spire Washington Hospital were 'extremely likely' or 'likely' to recommend the service to family and friends. The organisation's own patient satisfaction surveys demonstrated high levels of patient satisfaction. 90% of all patients responded 'excellent' to the care and attention provided by nursing staff and 82% responded 'excellent' to the patient experience. Appropriate emotional support was provided to patients. All women were offered a counselling service prior to termination of pregnancy. There was access to specialist advice and support when required.

Are services responsive at this hospital

There was service planning within the hospital in terms of monitoring out patient activity and bed availability within inpatients. The service was responsive to the needs of patients living with dementia and learning disabilities. Both wards had a dementia champion as well as a learning disability liaison nurse who could provide advice and support with caring for people with these needs by ensuring extra staff and carers were available. Pre-assessment appointments were held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. The hospital was meeting overall referral to treatment targets (RTTs). Theatre staff had an on-call arrangement to manage any unexpected returns to theatre. This arrangement included night and weekend cover. No patients had their operation cancelled and were not treated within 28 days between April 2014 and August 2015. The hospital had a robust complaints procedure. The patient outcome manager and clinical govemance lead met weekly to review all complaints, as well as discussing at the weekly clinical governance meetings. Complaints are also reviewed by members of the MAC and at the clinical governance committee. The Hospital Director and Head of Clinical Services sign off all complaints.

There was learning from complaints and examples of this were provided during the inspection.

Are services well led at this hospital

The hospital has an experienced and stable senior leadership team. There was strong local leadership of the service from the Hospital Director, the Head of Clinical Services and the Surgical Services Manager. The Surgical Services Manager also worked clinically and was seen by staff on a daily basis.Managers were approachable ,available and visible within the hospital. There was good staff morale and they felt supported at ward and department level. There were low rates of sickness absence within the hospital for all grades of staff. Vacancy rates for registered nurses were 18%, operating department practitioners 23% and care assistants 0%.The hospital was actively pursuing developing an initiative or using an initiative to attract and retain staff. There were robust arrangements in place between the senior management team and the MAC to monitor, agree and review practising priveleges. There was a comprehensive committee and meeting structure to ensure governance, risk and quality management was effective. These meetings included Hospital Leadership Team (HLT), clinical governance committee, risk committee and the MAC. Meetings were held monthly at both hospital and organisational levels and minutes of these meetings confirmed monitoring of risk, quality and governance. Fit and proper person requirements were being met at this hospital, with all required checks being in place for the relevant senior staff. There were examples of innovation and improvement.

Our key findings were as follows:

- Medical and nurse staffing levels were adequate on the wards, theatres, outpatients and disgnostic services. Staffing establishments and skill mix were reviewed regularly and levels increased to meet patient needs where required.

Summary of findings

- Arrangements were in place to manage and monitor the prevention and control of infection with a dedicated team to support staff and ensure policies and procedures were implemented.We found that all areas we visited were clean.
- There were no hospital acquired infections during 2014.
- There were no unexpected patient deaths during 2014.
- Processes were in place to ensure patients nutrition and hydration was effectively managed prior to and following surgery. Where required access to dietician input was available. Patients gave positive feedback about the choice and quality of food they received.
- There was sufficient equipment to ensure staff could carry out their duties. Processes were in place for monitoring and maintaining equipment.
- Staff understood their responsibilities to raise concerns and record patient safety incidents and near misses. There was evidence of a culture of learning and service improvement.
- Medicine management arrangements were in place. Medicines were stored securely and staff were competent to administer medicines.
- There were systems for the effective management of staff which included an annual appraisal. All doctors were appropriately vetted to ensure they had the skills to undertake surgical procedures.
- The hospital undertook a programme of local clinical audits depending on risk assessments. These covered a range of areas including infection prevention and control, medicines management and audits of radiology and clinical services.
- Senior and departmental leadership at the hospital was good. Leaders were aware of their responsibilities to promote patient and staff safety and wellbeing. Leaders were visible and there was a culture which encouraged candour, openness and honesty.

We saw several areas of good practice including:

- Patient forums were held for patients who had undergone endoscopy procedures.
- A breast cancer support group meets regularly and monitors the outcomes of patients who have undergone treatment for breast cancer.

However, there were also areas of poor practice where the provider needs to make improvements.

The provider should:

- Continue to monitor cleaning schedules and checks for expired equipment to ensure that they are completed correctly, particularly in the outpatient department.
- Review staff's understanding of Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS), particularly in the outpatient and diagnostic imaging departments .
- Ensure that all medication records show the name and role of the person administering medicines used for medical abortion.
- Ensure that nursing staff have appropriate formal training and competencies to care for women requiring termination of pregnancy.
- Ensure that all women undergoing termination of pregnancy are allowed to make choices with regard to their wishes and beliefs regarding sensitive and respectful disposal of pregnancy remains.
- Ensure staff are made aware that women might choose to dispose of pregnancy remains themselves and of the processes to enable this.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Good	In surgical services at this hospital, we rated safe, caring, effective and responsive as good, with well led being outstanding Local leadership was outstanding.Senior managers had a clear vision and strategy for the division and staff were able to repeat this vision and discuss its meaning with us during individual interviews. There was strong local and inspiring leadership of the service and quality care and patient experience was seen as everyone's responsibility. Locally, there were robust arrangements in place between the senior management team and the MAC to monitor, agree and review practising privileges and gain assurance of consultant competencies. There was also effective and comprehensive arrangements for medical cover out of hours. Governance meetings were held monthly and minutes of these meetings confirmed monitoring of risk, quality and governance, including patient ooutcomes.The hospital valued the importance of patient and staff feedback and there were robust mechanisms to hear and respond to patient views. Staff were encouraged to constantly review practice and knew how to identify risks and make suggestions for improvement. Patient areas were clean and bare below the elbow policies were adhered to. We saw the use of hand gel and there was sufficient personal protective equipment available to staff. There were clear procedures for the reporting and escalation of incidents and all staff were aware how to report them. A nurse staffing tool was used to review nursing establishments and skill mix to meet patient needs where required. Medicine management arrangements were in place. There were clear policies and procedures to keep patients and staff safe and safeguarded from abuse. Patients followed clear pathways of care and staff were able to recognise and respond to warning signs of rapid deterioration of patients health. Effective handovers took place between staff to ensure continuity and safety of care. Care records were clearly and accurately completed. There were processes in place for implementing and monitoring the use of evidence based guidelines and standards to meet patients care needs. Surgical services participated in national clinical audits and reviews to

Summary of findings

improve patient outcomes and had developed a number of local audits. Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams.
Nursing, medical and other health care professionals were caring towards patients and their dignity and privacy were protected. Patients spoke positively about their care and experiences.
Service planning, delivery to meet the needs of people as well as access and flow arrangements were in place. The service was responsive to the needs of patients living with dementia and learning disabilities.
Complaints were handled in line with the hospital policy.Information about the hospitals complaints procedure was available for patients and their relatives. There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Outpatients and diagnostic imaging

Good

Overall, the care and treatment received by patients using the outpatient and radiology departments was safe, effective, caring, responsive and well-led.
Care and treatment delivered by the outpatient and diagnostic imaging departments was safe and patients were protected from harm. Incidents were reported, investigated and lessons learned. The cleanliness and hygiene in the department was mixed, as some equipment we inspected had not been cleaned and some cleaning rotas were not up to date. However, we received assurances from the hospital including a performance improvement plan and supporting documents which had been shared with staff detailing how stocks would be appropriately maintained in the future. Staff adhered to the use of personal protective equipment. There was sufficient and well maintained equipment to ensure patients received the treatment they needed in a safe way. There were sufficient well trained and competent nursing and medical staffs within the department to ensure patients were treated safely.
Services provided by the outpatient and diagnostic imaging department were effective. Care and treatment was evidence based and patient outcomes were measured and within acceptable limits. Staff in the departments were competent, and there was evidence of multidisciplinary working.

Summary of findings

People were treated courteously and respectfully and their privacy was maintained. Services were in place to emotionally support patients. Patients were kept up to date with and involved in discussing and planning their treatment. Patients were able to make informed decisions about the treatment they received.
Outpatient and diagnostic imaging services were responsive to needs of patients. Patients were able to be seen quickly for urgent appointments, if required, and clinics were only rarely cancelled at short notice.
Mechanisms were in place to ensure the service was able to meet the individual needs of people such as those living with dementia, a learning disability or physical disability, or those whose first language was not English. Systems were in place to capture concerns and complaints raised within the department, review these and take action to improve the experience of patients.
Staff and managers had a vision for the future of the department and were aware of the risks and challenges faced by the department. Staff felt supported and were able to develop to improve their practice. There was an open and supportive culture where incidents and complaints were reported, lessons learned and practice changed. The department supported staff who wanted to be innovative and try new services and treatments.

Termination of pregnancy

Good

Termination of pregnancy services were safe, caring, effective, responsive and well led.
The ward area staff complied with best practice with regard to cleanliness and infection control. Incidents and risks were reported and managed appropriately and lessons learned and actions to be taken were cascaded to front line staff. Staff were aware of procedures to be followed in the case of a major incident.
Nursing and medical staffing was sufficient and appropriate to meet the needs of patients in their care. Medicines were stored and prescribed safely. However, medical abortion records did not always show clearly who had administered misoprostol tablets. Medical records were legible and assessments were comprehensive and complete, with associated action plans and dates.
There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Patient outcomes were monitored. Pain relief was prescribed

Summary of findings

pre and post-procedure and women were reassessed for pain following both types of abortion. Medical records were complete and written consent was obtained in all cases.Staff were trained and assessed competent for general nursing practice. However, they had no specific formal training or competency assessments to ensure they were able to meet the needs of the women who required termination of pregnancy services. Informal training had been provided by appropriate consultant staff.

There were no women attending out patients or the ward for consultation, procedures or advice during any of the days of our inspection. We were therefore unable to observe the way patients were treated by staff. However, we spoke with staff, reviewed patient feedback and information, and reviewed appropriate records during our visit. Staff told us how they involved and treated women with compassion, kindness, dignity and respect. The results of the Friends and Family test demonstrated that 98% of all patients at Spire Washington Hospital were 'extremely likely' or 'likely' to recommend the service to family and friends.

The service was responsive to the needs of women. Pre and post-procedure checks and tests were carried out at the hospital and waiting times were consistently within the guidelines set by the Department of Health. Interpreting and counselling services were available to all women and the hospital was accessible for those with disabilities. Information and advice were available to women at all stages of their episode of care and pregnancy remains were disposed of sensitively, although staff were unaware that women should be able to choose how this happened.Women were offered testing for sexually transmitted infections prior to any treatment but this was not consistent. There had been no complaints from women accessing the hospital for termination of pregnancy but there were robust and effective systems in place for managing complaints should they arise.

Senior managers had a clear vision and strategy for this service. There was strong local leadership of the service and quality care and patient experience was seen as all the staff's responsibility.

Staff felt proud of the service they provided and felt that they met the requirements of Department of Health (DH)

Summary of findings

Required Standard Operating Procedures and Royal College of Gynaecologists Clinical Guidelines. They felt supported to carry out their roles and were confident to raise concerns with managers.

Good

Spire Washington Hospital

Detailed findings

Services we looked at
Surgery; Outpatients & diagnostic imaging; Termination of pregnancy

Detailed findings

Contents

Background to Spire Washington Hospital

Spire Washington Hospital opened in 1988 as a joint venture involving a group of consultants and Independent British Hospitals. Since then it has been managed by Goldsborough Developments, Bupa Healthcare and is now operated by Spire Healthcare Limited.

The hospital was located two miles from Chester-le-street and Washington, and 11 miles south of Newcastle upon Tyne. It was registered as an acute hospital with 47 beds, and currently there are 36 beds that are operational. The hospital provided comprehensive hospital services to NHS and other funded patients (insurance and self-pay) predominantly from the Sunderland, Durham and Gateshead areas.

In addition to the usual hospital departments and facilities Spire Washington offered one two-bedded High Dependency Unit (HDU), which is a Level 2 facility, along with four theatres: of which three are laminar flow and a JAG accredited Endoscopy unit. The hospital also has an in-house ISO accredited Sterile Services Department, a 128 slice CT scanner, a 1.5T MRI scanner, and on site Pathology and Pharmacy services.

The Hospital's Senior Management Team comprised of the Hospital Director , the Head of Clinical Services, the Surgical Services Manager, the Finance and Commercial Manager and the Business Development Manager. The Hospital Director has been the CQC registered manager since 25 July 2013.

The hospital had not taken part in any special reviews or investigations by the CQC during 2014/15.The last inspection carried out in November 2013 showed the hospital was meeting all standards of quality and safety.

We inspected Spire Washington Hospital as part of our comprehensive inspections of independent hospitals. The inspection team inspected the following three core services:

- Surgery
- Outpatient and diagnostic imaging
- Termination of pregnancy.

Our inspection team

Our inspection team was led by:

Inspection Lead: Sandra Sutton, Inspection Manager, Care Quality Commission.

Detailed findings

The team included CQC inspectors and a variety of specialists including a consultant , non executive director, senior nurses with experience in surgery, termination of pregnancy and out patients, and an expert by experience who had experience of using healthcare services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We carried out the announced inspection of Spire Washington Hospital between 5 and 6 August 2015 along with an unannounced visit at the hospital on 18 August 2015. We talked with patients and members of staff including ward managers, nursing staff (qualified and unqualified), medical staff, allied health professionals, support staff and managers. We observed how patients were being cared for and reviewed patient's clinical records.

Prior to the announced inspection, we reviewed a range of information we had received from the hospital. We also asked the local clinical commissioning group to share what they know about the hospital.

Facts and data about Spire Washington Hospital

The Spire Washington Hospital provided comprehensive hospital services to NHS and other funded patients (insurance and self-pay) predominantly from the Sunderland, Durham and Gateshead areas. Spire Washington Hospital is registered as an acute hospital with 47 beds, and currently there are 36 beds that are operational. The hospital has 24 overnight beds and 12 day case beds.

Spire Washington Hospital provided a range of surgical services to both private and NHS patients predominantly from the Sunderland, Durham, and Gateshead areas. The hospital did not provide surgical services to children under sixteen. Private patients aged 16 to 18 were cared for under adult nursing services unless the child had specific nursing needs. If this was the case the child would be referred to an establishment with appropriate support. The NHS Standard Acute Contract excluded patients under the age of 18. The Hospital was supported by a Registered Children's Nurse employed at Spire Leeds Hospital. Registered Children's nurses would be made available if required.

The hospital offered 22 inpatient beds on Lambton Ward, a 12 day case unit on Sunniside Ward, a two bedded high dependency unit (HDU), a Level 2 facility, along with four theatres, of which three were laminar flow and an accredited endoscopy unit. The hospital had an in house accredited Sterile Services Department, and an onsite pathology and pharmacy services.

Between April 2014 and March 2015 the hospital had 7,884 inpatients, of which approximately 2,500 were day cases. The most commonly performed surgeries were spinal injections, knee arthroscopy, total hip and knee replacements, and injection of therapeutic substance into joints.

The hospital had an outpatient and radiology department hosting a number of different specialities including audiology, bariatric surgery, clinical psychology, orthopaedics, plastic surgery, ophthalmology, cosmetic surgery, gastroenterology, ear nose and throat, gynaecology, general surgery, vascular surgery, dermatology, rheumatology and oncology. Diagnostic imaging facilities included CT scanner, mammography, MRI scanner, ultrasound scanner and x-ray.

Detailed findings

From April 2014 to March 2015 the hospital outpatient department saw 32,539 patients. Of these, 11,465 were new appointments and 21,074 were follow-up appointments. The hospital saw 14,112 NHS appointments and 18,427 private patient appointments.

Spire Washington Hospital provided support, information, treatment and aftercare for women seeking termination of pregnancy. The service was part of the main outpatient and inpatient service, with outpatients offering consulting rooms, ultrasound scanning equipment, pharmacy, pathology and nursing staff to support patients throughout the consultation process, a ward with single occupancy en-suite rooms and a fully staffed and equipped operating theatre suite which included a dedicated recovery area with two high dependency beds for more complex patient needs. The Hospital held a licence from the Department of Health to undertake termination of pregnancy procedures. Most surgical abortions were carried out on women of early gestations (between six and eight weeks). Medical abortions were carried out on women of all gestations within the legal limits. 10 patients had undergone surgical abortion and 12 patients had undergone medical abortion in the 12 month period prior to our inspection.

Staffing

- 162 doctors and dentists were working under the rules of practising privileges.
- 12.1 full time equivalent (WTE) nurses were employed in inpatient departments, 13.2 in theatre departements and 7.7 in outpatients.
- 14.4 WTE Allied Health Professionals were employed at the hospital.
- 2.9 WTE healthcare assistants were employed in inpatients, 9.6 in theatre departments and 2.7 in outpatients.
- The Hospital Director has been the accountable officer for Controlled Drugs since 29 November 2013

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Termination of pregnancy	Good	Good	Good	Good	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	Good

Notes

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Outstanding
Overall	Good

Information about the service

Spire Washington Hospital provided a range of surgical services to both private and NHS patients predominantly from the Sunderland, Durham, and Gateshead areas. The hospital did not provide surgical services to children under sixteen. Private patients aged 16 to 18 were cared for under adult nursing services unless the child had specific nursing needs. If this was the case the child would be referred to an establishment with appropriate support. The NHS Standard Acute Contract excluded patients under the age of 18. The Hospital was supported by a Registered Children's Nurse employed at Spire Leeds Hospital.

Spire Washington Hospital offered 22 inpatient beds on Lambton Ward, a 12 day case unit on Sunniside Ward, a two bedded high dependency unit (HDU), a Level 2 facility, along with four theatres, of which three were laminar flow and an accredited endoscopy unit. The hospital had an in house accredited Sterile Services Department, and an onsite pathology and pharmacy services.

Between April 2014 and March 2015 the hospital had 7,884 inpatients, of which approximately 2,500 were day cases. The most commonly performed surgeries were spinal injections, knee arthroscopy, total hip and knee replacements, and injection of therapeutic substance into joints.

During this inspection we visited the Lambton and Sunnyside Wards, the four theatres and recovery areas on site, observed care being given and surgical procedures being undertaken.We spoke with 16 patients and relatives and 12 members of staff including nurses, allied healthcare professionals, resident medical officer (RMO), consultants, support staff and managers. We observed care and treatment and looked at care records for 10 patients.

Prior to and following our inspection we reviewed performance information about the hospital.

Surgery

Summary of findings

In surgical services we rated safe, caring, effective and responsive as good, with well led being outstanding

Local leadership was outstanding. Senior managers had a clear vision and strategy for the division and staff were able to repeat this vision and discuss its meaning with us during individual interviews. There was strong local and inspiring leadership of the service and quality care and patient experience was seen as everyone's responsibility. Locally, there were robust arrangements in place between the senior management team and the MAC to monitor, agree and review practising privileges and gain assurance of consultant competencies. There was also effective and comprehensive arrangements for medical cover out of hours. Governance meetings were held monthly and minutes of these meetings confirmed monitoring of risk, quality and governance.The hospital valued the importance of patient and staff feedback and there were robust mechanisms to hear and respond to patient views. Staff were encouraged to constantly review practice and knew how to identify risks and make suggestions for improvement.

Patient areas were clean and bare below the elbow policies were adhered to. We saw the use of hand gel and there was sufficient personal protective equipment available to staff. There were clear procedures for the reporting and escalation of incidents and all staff were aware how to report them. A nurse staffing tool was used to review nursing establishments and skill mix to meet patient needs where required. Medicine management arrangements were in place. There were clear policies and procedures to keep patients and staff safe and safeguarded from abuse. Patients followed clear pathways of care and staff were able to recognise and respond to warning signs of rapid deterioration of patients health. Effective handovers took place between staff to ensure continuity and safety of care. Care records were clearly and accurately completed.

There were processes in place for implementing and monitoring the use of evidence based guidelines and standards to meet patients care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes and had developed a number of local audits. Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams.

Nursing, medical and other health care professionals were caring. The dignity and privacy of the patients were protected. Patients) spoke positively about their care and experiences.

Service planning, delivery to meet the needs of people and access and flow arrangements were in place. The service was responsive to the needs of patients living with dementia and learning disabilities. Complaints were handled in line with the hospital policy, information about the hospitals complaints procedure was available for patients and their relatives. There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Surgery

Are surgery services safe?

Good

Surgical services were felt to be safe. Patient areas were clean and bare below the elbow policies were adhered to. We saw the use of hand gel and there was sufficient personal protective equipment available to staff.There were clear procedures for the reporting and escalation of incidents and all staff were aware how to report them. The hospital used the NHS Safety Thermometer which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

A nurse staffing tool was used to review nursing establishments and skill mix to meet patient needs where required. There was evidence to show that staff completed daily assessments of nursing staff as recommended by NICE guidelines Medicine management arrangements were in place. There were clear policies and procedures to keep patients and staff safe and safeguarded from abuse. Patients followed clear pathways of care and staff were able to recognise and respond to warning signs of rapid deterioration of patients health. Effective handovers took place between staff to ensure continuity and safety of care. Care records were clearly and accurately completed.

Incidents

- Nursing staff were knowledgeable about the reporting process for incidents using the electronic hospital incident reporting system. Staff said they were encouraged to report all incidents and that the senior management team demonstrated effective management of all incidents. Staff felt lessons were learned across the organisation.
- The hospital reported one Never Event since April 2015. This related to a wrong site regional local block. A comprehensive investigation was undertaken which resulted in clear findings, conclusions and actions taken. Not all staff appeared to understand the detail of this event. There had been no incidence of a Never Event between April 2014 and March 2015.
- The hospital reported two serious incidents between April 2014 and April 2015. Both incidents had an appropriate root cause analysis completed, with recommendations and action plans. Action plans were monitored and action points had been completed within the required timescales.
- Between April 2014 and March 2015 there had been 507 clinical incidents of which 15 were serious incidents requiring investigation (SIRI). Overall, the rate of clinical incidents (per 100 inpatient discharges) had fallen over this period.
- Between April 2014 and March 2015 the hospital had no unexpected deaths.
- All incidents and adverse events such as unplanned returns to theatre, transfers out and unplanned readmissions were discussed at the Medical Advisory Committee (MAC) and clinical governance committee. Minutes of MAC and clinical governance committee meetings confirmed this.
- Every member of staff we spoke with understood the principles of the Duty of Candour. Staff stated that they were provided with awareness training through management meetings.
- We observed an example of duty of candour being instigated in relation to a Never Event.

Safety thermometer

- The hospital used the NHS Safety Thermometer which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Performance was monitored by the senior management team and communicated to the wards and departments.
- Safety thermometer information included information about all new harms, falls with harm, urinary tract infections and new pressure ulcers and was displayed on boards on both wards and theatre areas visited.
- Between April 2014 and March 2015 safety thermometer information showed no urinary tract infections and that risk assessments were being appropriately completed for all patients on admission to the hospital.
- The hospital recorded six cases of hospital acquired venous thromboembolism (VTE) between April 2014 and March 2015 and a screening rate was above 95%. Following a review and implementation of an action plan, all patients were now screened for VTE.

Cleanliness, infection control and hygiene

Surgery

- The hospital reported 25 surgical site infections. These numbers equated to 0.5% of the total number of surgical operations completed, which was within expectations.
- There were no reported cases of clostridium difficile (C. Diff), Meticillin-resistant Staphylococcus aureus (MRSA) or Meticillin-sensitive Staphylococcus aureus (MSSA) between April 2014 and March 2015. All patients meeting the providers screening criteria were screened for MRSA and procedures were in place to isolate patients when appropriate in accordance with infection control policies.
- There was clear Infection control information and this was displayed throughout the hospital.
- The 'Infection Prevention and Control Annual Plan' (2015) detailed the activities to ensure the hospital met the requirements of the Department of Health, Hygiene Code of Practice.
- This programme of work was mapped to the compliance criteria within the Hygiene Code of Practice and included systems to manage and monitor the prevention and control of infection, maintain a clean and appropriate environment and ensure all staff are fully involved in the process of preventing and controlling infection.
- We spoke with the lead infection control nurse who outlined recent infection control audit outcomes and action plans. We saw yearly audit plans for key infection control areas including, for example, surgical equipment, facilities for hand hygiene, floors, chairs, tables, high and low surfaces, curtains.
- Infection control audits were completed monthly and the latest available (June 2015) showed theatre areas and the Lambton Ward scored 100% compliance. The Sunniside Ward scored 92% and we saw action plans had been developed to address areas of non-compliance (floors, walls and overall appearance).
- All wards and patient areas were clean and we saw staff wash their hands and use hand gel between treating patients. Separate hand washing basins, hand wash and sanitizer was available on the wards, theatre and patient areas. Staff adhered to the bare below the elbow policy.
- Patient Led Assessments of the Care Environment (PLACE) audits rated the hospital as 100% for cleanliness (national average 97%) in 2014.

Environment and equipment

- We observed checks for emergency equipment and found them to be up to date and fully completed.
- The main ward offered single use rooms with suction equipment, piped oxygen with emergency call facilities.
- Electrical equipment portable appliance testing (PAT) had been carried out and labels were clearly evident and in date.
- There was adequate equipment to ensure safe patient care.
- Theatre air supplies were changed up to twenty times each day.
- We found some swabs (3) and dressings (3) out of date when checked. These items were located on a general trolley within the Sunniside ward. This did not comply with local policy LWI-HOP-47
- Surgical services manager who took immediate action to replace the items. Stock control was also outlined in the performance improvement plan.

Medicines

- All area's we visited showed appropriate lockable storage facilities for medicines.
- Records showed drug fridge temperatures were checked daily.
- Single rooms offered separate lockable facilities to store patients own medicines. There was a clear policy evidenced for the self-administration of medicines.
- Controlled drug records were checked and medication record administration forms and found to be clear, concise and fully completed.
- The hospital pharmacy was visited which was well organised and managed. We observed that pharmacists ensured that each patient was visited prior to discharge to ensure that they had a full understanding of the medicines that they were prescribed. Discharge did not take place after 9pm.
- There was evidence to show that clinical medication audits were in place for example medication used during colonoscopy in 2014. The results of which showed that there were no issues with sedation usage within the unit.

Records

- Records were stored safety and securely in line with the Data Protection Act.
- White boards displayed clinical activity for each day and maintained patient confidentiality.

- Care pathways were used clearly in all records that were checked (ten records).
- Nursing documentation was kept at the end of the bed and centrally within the wards and was completed appropriately.
- We observed record keeping, medication and documentation audits. Results showed a general improvement in most areas in the period April 2014 – March 2015. For example ward and staff compliance completing the pre op checklist fully had improved from 52% to 92% for ward staff and 84% to 95% for theatre staff.

Safeguarding

- Staff were aware of the safeguarding policies and principles within the hospital.
- Safeguarding policies were clearly visible on the ward and accessible for staff.
- Staff when asked were clearly able to demonstrate their understanding of the policy.
- Training data showed staff received yearly refresher training and 83% of staff had completed Safeguarding Adults and children level 1 training, with 6% of staff waiting to complete the training for the first time. 75% of staff had completed level 2 Safeguarding Children training.
- One safeguarding concern had been reported within the last twelve months. A clear action plan was evidenced with a concise management plan. Information had been disseminated and lessons had been learnt.

Mandatory training

- Performance reports provided by the hospital showed staff were up to date with their mandatory training. For example, within theatres 85% of staff had completed or had mandatory training arranged, on the wards this was 88%. These rates were year to date at the time of the inspection. The hospital has a 95% target for all training modules by the end of the calendar year.
- Across the hospital, completed and arranged mandatory training was 100% for valuing people and respecting differences, 100% for MCA training, 100% for risk assessments training, 89% for safeguarding adults and 89% for infection control.
- Staff we spoke with confirmed they were up to date with mandatory training and this included attending annual cardiac and pulmonary resuscitation training.
- All staff we spoke to felt that they were encouraged with their professional development and allowed time to complete mandatory training.

Assessing and responding to patient risk

- All patients were risk assessed at point of admission and we saw there was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Pre-assessment of patients was in accordance with British Association of Day-care Surgery (BADS) guidelines.
- All wards completed appropriate risk assessments and these included risk assessments for falls, pressure ulcers and malnutrition. All records we looked at were completed accurately.
- Due to the changing numbers of admissions staffing ratios were adjusted according to the nature and number of patients attending on any given day.
- We evidenced clear patient pathways which included escalation policies for the deteriorating patient. Wards used an early warning scoring system for the management of deteriorating patients. There were clear directions for escalation printed on the observation charts and staff spoken with were aware of the appropriate action to be taken if patients scored higher than expected.
- There was a transfusion policy for post-operative patients, with an aim to set a haemoglobin trigger of 8g/Dl. The policy included comprehensive guidance on the pre-transfusion testing, requests for transfusion and collection and delivery of blood. Staff we spoke to were aware of the policy and its contents.
- The hospital had a blood bank for emergency use.
- Audits of completing the World Health Organisation (WHO) surgical safety checklist in operating theatres were completed. Checklist audits showed 100% compliance .
- There is a resident hospital doctor on site 24 hours a day, 7 days per week.
- Staff advised us that they have access to consultant advice regularly but can call upon the services of the resident doctor if required.
- In the two bedded high dependency unit (HDU) facility, the environment was suitable for the care and treatment of HDU patients and staff were all appropriately trained.
- At the time of the inspection there were no patients being cared for in the HDU facility.

- Policies and procedures were in place for transfer and escalation of patients being cared for in HDU and on the ward to local NHS hospitals when necessary.
- The hospital had links to local NHS trusts and was part of the local critical care network.

Nursing staffing

- The ward used a minimum nurse staffing ratio of one registered nurse to five patients during the day and one registered nurse for seven patients overnight, with two registered nurse on duty at all times. We reviewed eight weeks of nursing staff rotas which confirmed this.
- A daily assessment of nursing staff requirement was completed to ensure the nursing needs of patients are met throughout the full 24 hour period as recommended by NICE guidelines. Staff worked flexible shifts to allow for changes such as late theatre lists.
- A staffing level tool was used in accordance with patient dependency and risk.
- There was a vacancy rate of 15% for nursing staff within inpatient services and an 18% rate in nursing staff in the theatre departments (31 March 2015). Both departments showed a low level of sickness below 10%.
- Nurse handovers occurred three times a day. We observed a handover during our inspection visit, this was clear and discussed patient care and their needs.
- The hospital recently trialled the 'Shelford Safe Staffing' tool as part of a Spire project, which was being reviewed corporately.
- Agency qualified staff were not used on the wards, within inpatient services; an internal nurse 'bank' was used to fill any staff shortages.
- The ward sister was supernumerary to the staffing figures and covered vacancies, if necessary, to ensure safe patient care.

Medical staffing

- All patients were admitted under the care of a named consultant. Consultants reviewed their patients daily. Out of hours they were available to be contacted by the Resident Medical officer (RMO). Staff and RMO we spoke with raised no concerns about the support they received from consultants or their availability.
- The hospital had information ,electronically and accessible to all staff, which outlined consultant cover and cross cover arrangements.
- The consultant handbook stated that all consultants must arrange suitable cross cover from a 'suitably skilled colleague, with practising privileges for periods that they are unable to attend the hospital'. Consultants and staff we spoke with were aware of this arrangement.
- The hospital's resident doctor and department heads are issued with 'on call' rotas. The hospital employed RMOs who lived on site while they were on duty and worked a seven day rota. There was 24 hour medical cover by the RMOs.
- Contingency plans were in place to obtain cover if the RMO was called out during a significant portion of the day or night.
- There were processes in place for the handover of patients.The RMO received patient information from nursing staff at each shift change and from consultants before they went off duty.

Major incident awareness and training

- The hospital had processes in place to ensure compliance with NHS England core standards for emergency preparedness, resilience and response.
- The hospitals major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency.

Are surgery services effective?

Good

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes.

There was effective communication and collaboration between multidisciplinary teams, which met regularly to identify patients requiring visits or to discuss any changes to the care of patients. Patients received care and treatment from competent staff. Patients were risk assessed appropriately and effective pain relief arrangements were in place.

Evidence-based care and treatment

Surgery

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, Great Britain and Ireland and the Royal College of Surgeons. Care pathways were used for all patients undergoing surgical procedures.
- Local policies were written in line with national guidelines and updated every three years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- The hospital took part in all the national clinical audits that they were eligible. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- Local audits within surgery were used to ensure care and treatment was evidence based. Audits were carried out for example on medical records, care pathways, infection control, early warning scores, consultant documentation, surgical site infections, patient temperature, pain control and use of personal protective clothing in theatres and recovery.

Pain relief

- Pre-planned pain relief was administered for patients on recovery pathways. Patients who underwent surgery followed a pathway that had been developed to ensure patients were provided with defined pre-operative, peri-operative and post-operative analgesia.
- There was a pain assessment scale within the National Early Warning Score (NEWS) chart used throughout the hospital. NEWS audits were in place and showed 100% completion.
- We reviewed 10 integrated care pathway records and saw pain relief for patients undergoing a variety of procedures was documented in all records.
- Patients told us pain relief arrangements were in place. Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.
- All patients we spoke with reported their pain management needs had been met.
- The hospital had undertaken an audit of post-operative pain relief with patients and this showed 100% of patients believed their pain relief needs had been met.

Nutrition and hydration

- Patients were screened using the Malnutrition Universal Screening Tool (MUST). Where necessary staff told us they could access advice when required if patients were at risk.
- MUST was in place and documented within the integrated care pathway records. Records showed these had been completed accurately.
- Nausea and vomiting was formally assessed using a scoring system and recorded. The patient records we reviewed confirmed this had been carried out.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on when the surgery was planned.
- A variety of food was available that included, vegetarian options, gluten-free, lighter options and multi-cultural food choices.

Patient outcomes

- The standardised 30 day emergency readmission rates are similar to expected for hernia procedures, hip replacement procedures and knee replacement procedures compared to other independent hospitals.
- The hospital reported (2014) a rate of 0.40 unplanned readmissions per 100 inpatient discharges.
- There were 7922 visits to theatre between April 2014 and March 2015 and 14 cases of unplanned return to theatre during the same period ('similar to expected' for independent acute hospitals).
- The hospital reported a rate of 0.05 (2014) unplanned transfers of inpatients to another hospital per 100 inpatient discharges. The proportion of unplanned transfers to another hospital was better than expected and cases of unplanned transfers were discussed at clinical governance meetings.
- The hospital outcomes for the Patient Reported Outcome Measures (PROMS) 2014 for hip replacement and knee replacement primary scores showed the percentage of patients that had improved for each procedure was 'not significantly different' to the England average.

Competent staff

- Staff told us that appraisals were undertaken annually and records for 2014 showed that 91% staff across all wards in surgery and theatres had received an appraisal during 2014.

- Staff told us they were encouraged to undertake continuous professional development and were given opportunities to develop their clinical skills and knowledge through training relevant to their role.
- Appraisals were linked to the hospital vision and values and the group strategy. Staff told us their objectives were set at appraisal and learning needs and further training was discussed and planned.
- These were supported by informal one to one meetings.
- Systems were in place for revalidation and appraisal of medical staffing and for the effective management of doctors which included an annual appraisal. Appraisals were based on General Medical Council (GMC) guidance and completed by a medically qualified appraiser.
- All cosmetic surgeons were on the specialist register for cosmetic medicine and vetted to ensure they had the required competency and skills.
- The hospital recorded 100% validation for nurses working within the inpatient department.
- Fitness to practice issues for consultants were assessed by the MAC and any competency issues discussed with the appropriate senior manager from the employing NHS Trust.

Multidisciplinary working

- Therapists worked closely with the nursing teams on the wards where appropriate. Ward staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists when needed. Records showed details of specialist referrals, including those made to community nursing teams and occupational therapy services.
- Daily handovers were carried out with members of the multidisciplinary team. The hospital employed its own physiotherapists and pharmacists. This meant that multidisciplinary team support was available if patients required it.
- There was pharmacy input on the wards during weekdays and dedicated pharmacy provision for each ward.
- Staff explained to us the wards worked with local authority services as part of discharge planning.
- Effective team working between ward and theatre staff was observed and we saw interactions, interventions and treatment were recorded.
- Discharge letters were sent to the patient's general practitioner (GP) and a copy of the letter provided to the patient. We confirmed this through a review of discharge records and spoke with patients ready for discharge.

Seven-day services

- Daily ward rounds were arranged for all patients and patients were seen on admission at weekends.
- Pharmacy staff were available on site during the week and on-call arrangements were in place, including out of hours and weekends. The hospital pharmacy was open Monday to Friday between the hours of 8:30am and 4:30pm. We were informed that advanced prescribing was in place for those patients who were discharged at weekends.
- The hospital's radiology and physiotherapy services were available Monday to Thursday 8am to 8pm and 8am to 5pm on Fridays and Saturdays. There was an on-call arrangement at all other times.
- Resident Medical Officer cover was available 24 hours a day, 365 days a year and consultants provided 24 hour on-call (off site) cover for their patients. If they were unavailable at any time they organised a consultant colleague with admitting rights to provide cover ('cross cover') in their absence.
- Theatres and the endoscopy suite were available Monday to Friday between 8 am and 9 pm and from 8 am to 6 pm on a Saturday, with occasional sessions on a Sunday between 8 am and 1 pm.

Access to information

- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Staff had access to policies, procedures and guidance through the hospital intranet.
- Care pathway records contained all of the information staff needed to deliver effective care and treatment and included risk assessments, care plans and medical notes. Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment and we saw these were available to staff enabling effective care and treatment.
- We reviewed discharge arrangements and these were started as soon as possible for patients. We saw

discharge letters were completed appropriately and shared relevant information with a patient's general practitioner, other healthcare professionals and a copy given to the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records showed patients gave consent to treatment during pre-assessment. Care pathways required consent had to be given for on-going treatment and care. We reviewed twelve consent forms and saw these were completed appropriately.
- Patients confirmed they had received sufficient information regarding the risks and benefits of surgery to enable them to make an informed choice.
- Staff said they had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), records provided (June2015) showed 75% staff compliance with this training. The hospital had introduced a designated lead for MCA and DoLS.
- The hospital admitted patients with a dementia for surgery pre-assessment documentation confirmed their care was planned to meet individual needs. An multi-disciplinary team approach was undertaken which included family and carers.

Are surgery services caring?

Good

All staff showed a caring approach towards their patients. Patients and visitors spoke of staff being 'friendly and approachable' and stated they 'couldn't do enough'. Patients told us that they had received information from both doctors and nurses so that they understood their treatments and care options.

Information was offered to patients who required emotional support. This was displayed in the patient handbook as well as the general display boards.

Patient satisfaction was a priority and data was collated to measure patient satisfaction across a multitude of areas. The rate of patient satisfaction was high.

Compassionate care

- We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital. We saw that patients were spoken and listened to promptly. Patients were complimentary about the staff in the service, and felt informed and involved in their care and treatment. We observed patients were kept informed throughout their time within the anaesthetic room and theatres.
- Patients told us staff were 'very friendly and approachable'. Nurses and doctors were observed greeting patients in the reception area and escorting them to their relevant ward areas.
- Information was shared discreetly and we observed nurse handovers which maintained patient confidentiality.
- Staff were attentive to the comfort needs of patients. Patients and relatives were positive about the care and treatment they had received.
- The group's Friends and Family Test response rates were consistently high for patients between October 2014 and March 2015, with a steady increase in both response rates and scores for the final month.
- Between October 2014 and March 2015 between 98 and 100% of patients would recommend this hospital to friends and family.
- In the Patient Satisfaction Survey (May 2015), 99% of patients said they were extremely likely or likely to recommend the hospital to family or friends if they needed similar care or treatment, 90% of all patients responded 'excellent' to the care and attention provided by nursing staff and 82% responded 'excellent' to the patient experience.

Understanding and involvement of patients and those close to them

- Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the consultant looking after them.
- We saw that ward managers and matrons were available on the wards so that relatives and patients could speak with them.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- Staff we spoke to stated that each patient had a 'named nurse'.

Emotional support

- Patients felt able to approach staff if they felt they needed any aspect of support.

- Staff spoke to us about advocacy, counselling and mental health support services that were offered to all patients who required them.
- It was recorded in patient pathways when patients had a particular anxiety or concern and the appropriate actions taken.

Are surgery services responsive?

Good

We found the service was responsive. Service planning, delivery to meet the needs of people and access and flow arrangements were in place. The service was responsive to the needs of patients living with dementia and learning disabilities.

Complaints were handled in line with the hospital policy and were discussed at monthly staff meetings where training needs and learning was identified as appropriate. Information about the hospitals complaints procedure was available for patients and their relatives. There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Service planning and delivery to meet the needs of local people

- All admissions for surgery were planned in advance and included private patients and NHS patients. There was no differentiation between NHS or private patients.
- We saw effective arrangements were in place for collaborative working between consultants, nursing and operating department practitioners.
- Meetings were held to monitor the availability of beds in the hospital; staff reviewed data on planned patient discharge to assess the future availability of beds. At the time of our inspection there were no pressures on the numbers of beds available.

Access and flow

- A pre-assessment meeting was held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. The hospital had developed a Pre-Operative assessment Team. Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- The hospital was meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral (April 2014 to March 2015). The RTT was met (100%) for all specialities - general surgery, trauma and orthopaedics, neurosurgery, plastic surgery, gynaecology and ENT (100%). During this period, one patient was not treated within the 18 week target.
- Access and flow was linked to the hospital's booking system and surgery was elective other than those patients who had to return to theatre unplanned.
- Theatre staff had an on-call arrangement to manage any unexpected returns to theatre. This arrangement included night and weekend cover.
- Patients received staggered appointment times to reduce the need for fasting pre-operatively for long periods before surgery.
- A registered nurse admitted and discharged patients and retained responsibility for the patients care. This meant patients had timely access to care and treatment and action had been taken to minimise the time they had to wait.
- No patients had their operation cancelled and were not treated within 28 days between April 2014 and August 2015. There were 320 'day of procedure' cancellations during that period; the main reason was 'failure to attend' (63).

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. Both wards had a dementia champion as well as a learning disability liaison nurse who could provide advice and support with caring for people with these needs by ensuring extra staff and carers were available.
- We saw suitable information leaflets were available in easy read formats and described what to expect when undergoing surgery and postoperative care. These were available in languages other than English on request.
- Wards had access to interpreters as required, requests for interpreter services were identified at the pre-assessment meeting.

- There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- Discharge planning commenced at the pre-assessment stage. Planning for discharge continued during admission with specialists such as social services being identified and arranged for while the patient was in the hospital.
- We saw rooms were available near to the nurse's station when one to one care was required.

Learning from complaints and concerns

- Complaints were handled in line with hospital policy. Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward sister and staff were able to explain this process.
- The hospital received 44 complaints in 2014. This was a decrease from the previous two years.
- We saw leaflets available throughout the hospital informing patients and relatives about this process and information was given to patients about how to make a comment, compliment or complaint. Patients were given an opportunity to raise concerns with any staff member whilst at the hospital.
- The hospital's 'Please talk to us' leaflets were available in clinical areas and in reception and these detail how patients can raise concerns. Patients were also able to email the customer service desk and the Friends and Family Test discharge questionnaires were given to all in-patients, day case patients and those attending outpatient appointments.
- Private patients could also contact ISCAS (Independent Sector Complaints Adjudication Service), which was outlined in the 'Please talk to us' leaflets.
- Complaints were reviewed at the complaints meeting between the Clinical Governance Lead and the Patient Outcome Manager, weekly and quarterly clinical governance meetings, Medical Advisory Committee (MAC) meetings, Senior Management Team meetings and departmental team meetings. Minutes of meetings confirmed this.
- Action plans were reviewed monthly with the Clinical Governance Lead and head of department, outcomes were documented and audited for compliance.
- We saw that changes to practice had resulted from this process. For example, improved information had been provided to patients on potential charges for one stop breast clinics, additional hot food choices on the evening menu , and the change of practice regarding information given during the consent process and the requirement to counter sign consent.

Are surgery services well-led?

Outstanding ☆

Local leadership was outstanding. Senior managers had a clear vision and strategy for the division and staff were able to repeat this vision and discuss its meaning with us during individual interviews. This was proactively reviewed and reflected best practice. There was strong local and inspiring leadership of the service and quality care and patient experience was seen as everyone's responsibility. Locally, there were robust arrangements in place between the senior management team and the MAC to monitor, agree and review practising privileges and gain assurance of consultant competencies. There was also effective and comprehensive arrangements for medical cover out of hours. Governance meetings were held monthly and minutes of these meetings confirmed monitoring of risk, quality and governance including monitoring of patient outcomes.

The hospital valued the importance of patient and staff feedback and there were robust mechanisms to hear and respond to patient views. Staff were encouraged to constantly review practice and knew how to identify risks and make suggestions for improvement.

At ward and theatre levels we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.

Vision, strategy, innovation and sustainability for this core service

- We met with senior managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division. Staff were able to repeat this vision and discuss its meaning with us during individual interviews.

- The hospital vision and strategy was well embedded with staff, who were able to articulate to us the hospital's values and objectives across the surgical wards and they were clearly displayed in ward areas.
- We were told the hospital had a commitment to delivering high quality care with robust assurance and safeguarding and saw this in practice during the inspection. A caring and compassionate service was the main focus of the hospital's values.
- Staff were proud of the job they did and felt empowered to deliver a caring service by being supported by strong hospital leadership.

Governance, risk management and quality measurement

- Clinical governance (CGC) and Hospital Leadership Team (HLT) meetings were held each month; we saw that these were subject to constant review to reflect best practice throughout the group and ensure continued effective patient care and treatment.
- Locally, there were robust arrangements in place between the senior management team and the MAC to monitor, agree and review practising privileges and gain assurance of consultant competencies. There was also effective and comprehensive arrangements for medical cover out of hours.
- Agendas and minutes showed audits, learning from complaints, learning from clinical risk management, peer review data, patient and public information involvement, infection control issues, good practice, clinical audits were discussed and action taken where required.
- The hospital risk register was updated following these meetings and when needed. Risks were assigned to specific staff responsible for the monitoring of actions and the revision of the risk assessment as required. Reports identified risks, actions taken to address risks and changes in performance. These monitored (amongst other indicators) infection rates, RTTs, complaints, never events and clinical incidents.
- We saw that action plans were monitored and all staff implemented elements of action plans where appropriate, the risk register reflected identified risks and progress addressing them.
- There was a proactive approach to monitoring and measuring quality and safety in surgical services. We saw the Head of Clinical Services carried out regular audits.
- The hospital Quality Account report (2014) showed compliance against a variety of indicators, such as PROMs, infection rates, unplanned returns to theatre and unplanned readmissions. Where improvements were required staff roles and responsibilities were identified to carry out the actions and disseminate learning to staff.
- Theatres, endoscopy and the wards were represented at clinical governance and Medical Advisory Committee (MAC) meetings. Minutes (May and June 2015) showed areas discussed included departmental feedback on operational and clinical issues (e.g. completion of risk assessments,, WHO checklist, completion of early warning scores, intraoperative fluids and patient temperature checks), Safety Thermometer information, risks, staffing and complaints.
- Effective processes were in place for granting practicing privileges to enable doctors to work at the hospital. Approval to grant, restrict or withdraw practicing privileges was considered by the MAC with involvement of the hospital director. Records demonstrated doctors had to have the relevant clinical experience to practice in an independent hospital, personal audit data and patient outcome measures and references from peer practitioners.
- Procedures were in place to ensure surgeons had an appropriate level of valid professional indemnity insurance. We looked at staff files and found indemnity arrangements were appropriate and valid. The hospital monitored the current status of practicing privileges, GMC registration and indemnity arrangements. Administrative staff reviewed the information on a daily basis and sent reminders to doctors whose registration had lapsed.
- There was evidence of learning from other hospitals in the group through the compilation of performance data and distribution through the Healthcare Quality Report.

Leadership of service

- There was strong local leadership of the service focused on delivering high quality care from the Hospital Director, the Head of Clinical Services and the Surgical Services Manager. The Surgical Services Manager also worked clinically and was seen by staff on a daily basis.
- Staff said all managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level. All staff told us they felt

inspired by senior managers within the hospital and this encouraged them to be engaged in the provision of services and increased their individual and team motivation.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience is a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers and particularly the Head of Clinical Services and the Surgical Services Manager. Staff said they could report any concerns they had about the service or practice and said it would be listened to and addressed.
- Consultants felt there was a good working relationship and engagement with the hospital leadership team and staff and they were involved with clinical governance issues.
- The Hospital Director and Head of Clinical Services had both worked in other roles of varying seniority within the hospital and had been promoted to their current positions which demonstrates good understanding of the hospital and was inspiring for staff in the opportunities available for progression.

Culture within the service

- At ward and theatre levels we saw staff worked very well together and there was respect between specialities and across disciplines. We saw examples of strong collaborative team working on the wards between staff of different disciplines and grades.
- Staff were well engaged with the rest of the hospital and reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and responsibility of all staff.
- Staff said they were proud of the hospital as a place to work.
- The hospital had developed procedures for the discussion of 'Duty of Candour' issues with patients and families and these were handled by the Head of Clinical Services and Hospital Director and relevant clinicians.
- There were low rates of sickness absence (March 2015) for registered nurses (0%), operating department practitioners (1%) and care assistants (2%). Vacancy rates for the same staff groups were registered nurses (18%), operating department practitioners (23%) and care assistants (0%). The Surgical Services Manager told us the hospital was actively pursuing developing an initiative or using an initiative to attract and retain staff.

Public and staff engagement

- The Friends and Family Test response rate was higher than the England average of 32%, in February and March 2015 (45% and 50%) and scores higher across all areas than the England averages during that period.
- We saw patients rated the quality of service at the hospital at 98% (2014); this rated the hospital as second within the group.
- In the Patient Satisfaction Survey, 99% of patients said they were extremely likely or likely to recommend the hospital to family or friends if they needed similar care or treatment. All patients (100%) said they received appropriate care and attention from nurses and also staff controlled their pain (June 2015). The majority of patients said the admission process met their needs (99%) and they had been adequately prepared for their time at the hospital (99%).
- The Head of Clinical Services and the Surgical Services Manager gathered patient views and experiences, by telephoning patients after they had been discharged from the hospital. This was a key driver for how services were provided as results were logged and acted on.
- Challenging personal objectives were set for individual members of staff through the hospitals appraisal systems and these encouraged staff to review and develop working practices.
- Patient forums were held for patients who had undergone endoscopy procedures.
- A breast cancer support group meets regularly and monitors the outcomes of patients who have undergone treatment for breast cancer.

Innovation, improvement and sustainability

- The development of the Surgical Services Manager role had ensured continuity between surgical wards and theatres.
- The Pre-Operative Assessment Team ensured patients were appropriately prepared for and informed about their surgical procedure.
- Staff felt encouraged to learn and improve through an effective appraisal system, linked to the hospital's vision and strategy.

Surgery

- There were systems in place to improve performance which included the collection of national data, audit and learning from complaints and incidents.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Spire Washington Hospital had an outpatient and radiology department hosting a number of different specialities including audiology, bariatric surgery, clinical psychology, orthopaedics, plastic surgery, ophthalmology, cosmetic surgery, gastroenterology, ear nose and throat, gynaecology, general surgery, vascular surgery, dermatology, rheumatology and oncology. Diagnostic imaging facilities included CT scanner, mammography, MRI scanner, ultrasound scanner and x-ray. The hospital provided outpatient consultations only to children under the age of sixteen. No invasive procedures were performed in outpatients, including phlebotomy. Diagnostic imaging and physiotherapy services were also not available to children under sixteen.

From April 2014 to March 2015 the hospital outpatient department saw 32,539 patients. Of these, 11,465 were new appointments and 21,074 were follow-up appointments. The hospital saw 14,112 NHS appointments and 18,427 private patient appointments.

During the inspection we visited the outpatient, physiotherapy, endoscopy, oncology and radiology departments.

We spoke with nine patients, two nurses, three consultant, two administrative staff, two medical laboratory assistants, four physiotherapist, one manager, one healthcare assistant and three pharmacy staff. We observed the outpatient and radiology environment, checked equipment and looked at patient information. We also reviewed nine patient medical records as well as performance information from the hospital.

Outpatients and diagnostic imaging

Summary of findings

Overall, the care and treatment received by patients using the outpatient and radiology departments was safe, effective, caring, responsive and well-led.

Care and treatment delivered by the outpatient and diagnostic imaging departments was safe and patients were protected from harm. Incidents were reported, investigated and lessons learned. The cleanliness and hygiene in the department was mixed, as some equipment we inspected had not been cleaned and some cleaning rotas were not up to date. However, staff adhered to the use of personal protective equipment. There was sufficient and well maintained equipment to ensure patients received the treatment they needed in a safe way. There were sufficient well trained and competent nursing and medical staffs within the department to ensure patients were treated safely.

Services provided by the outpatient and diagnostic imaging department were effective. Care and treatment was evidence based and patient outcomes were measured and within acceptable limits. Staff in the departments were competent, and there was evidence of multidisciplinary working.

People were treated courteously and respectfully and their privacy was maintained. Services were in place to emotionally support patients. Patients were kept up to date with and involved in discussing and planning their treatment. Patients were able to make informed decisions about the treatment they received.

Outpatient and diagnostic imaging services were responsive to needs of patients. Patients were able to be seen quickly for urgent appointments, if required, and clinics were only rarely cancelled at short notice.

Mechanisms were in place to ensure the service was able to meet the individual needs of people such as those living with dementia, a learning disability or physical disability, or those whose first language was not English. Systems were in place to capture concerns and complaints raised within the department, review these and take action to improve the experience of patients.

Staff and managers had a vision for the future of the department and were aware of the risks and challenges they faced. . Staff felt supported and were able to develop to improve their practice. There was an open and supportive culture where incidents and complaints were reported, lessons learned and practice changed. The department supported staff who wanted to be innovative and try new services and treatments.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

Care and treatment delivered by the outpatient and diagnostic imaging departments was safe and patients were protected from harm. Incidents were reported, investigated and lessons learned. The cleanliness and hygiene in the department was mixed, as some equipment we inspected had not been cleaned and some cleaning rotas were not up to date. However, we received assurances from the hospital including a performance improvement plan and supporting documents which had been shared with staff detailing how stocks would be appropriately maintained in the future. Staff adhered to the use of personal protective equipment. There was sufficient and well maintained equipment to ensure patients received the treatment they needed in a safe way.

Staffs were aware of the policies to protect vulnerable adults or those with additional support needs. Patients were asked for their consent before care and treatment was given. There were sufficiently well trained nursing and medical staff within the department to ensure patients were treated safely. Staff told us they were aware of their responsibilities in the light of major incidents.

Patients were, protected from receiving unsafe care, because medical records were available for outpatient clinics.

Incidents

Outpatients

- Between April 2014 and March 2015 there were 44 outpatients incidents. Seven were graded as very low harm, 24 low or minor harm and 13 moderate harm. The main theme identified was surgical site infection identified as an outpatient within 31 days of surgery. Swabs were taken and patients were commenced on antibiotics.
- All staff were aware of how to follow the hospital's policies and procedures for reporting incidents. Incidents were reported and investigated in line with corporate policies.
- Managers within outpatients told us they provided staff with verbal feedback from incidents at team meetings. Staff confirmed the manager fed back the learning from incidents and discussed how they could do things differently to improve.

Diagnostic Imaging

- In the Diagnostic Imaging department, all staff were aware of hospital policy, procedures and reporting of incidents. Each policy, procedure and risk assessment was signed by the employee to state they had read and understood the information provided.
- Three incidents were reported on the Strategic Executive Information System (STEIS), action plans created and target dates for completed set. Evidence of Lesson Learned procedures are recorded with appropriate actions plans.
- Between April 2014 and March 2015 12 incidents had been reported in Radiology; one was classified as moderate, eight low/minor and three very low. Of these five were noted as no harm caused, one minor injury resulting in first aid, two moderate requiring pain relief and further x-ray due to a fall and three of a major severity recorded relating to staff injury (needlestick and two falls).
- We saw the recommended actions and lessons learned from the moderate incident which had been actioned in a timely manner. The radiology department had taken practical steps to reduce the likelihood of future errors by amending the associated policy.
- Reporting had been undertaken in accordance with Ionising Radiation (Medical Exposure) Regulations (IR(M)ER) protocol.
- The hospital was not an outlier in terms of IR(M)ER notifications.
- We saw comprehensive risk assessments which were up-to-date and stored for easy access by all staff members.
- Staff told us they were all encouraged to report concerns and record incidents. They told us managers were open to comments and suggestions for improvements from staff.

Cleanliness, infection control and hygiene

Outpatients

Outpatients and diagnostic imaging

- Between the reporting period of April 2014 and March 2015 there were no incidences of Clostridium Difficile (C.Diff), no incidence of Methicillin-resistant Staphylococcus Aureus (MRSA) or Meticillin-sensitive Staphylococcus Aureus (MSSA).
- Clinical and non-clinical areas in outpatients and diagnostic imaging generally appeared clean and tidy, with equipment stored appropriately.
- Housekeeping cleaning schedules were visible, checked, signed and up to date for all outpatient areas however these excluded treatment rooms.
- During our inspection we reviewed cleaning and checking schedules for the treatment rooms in the outpatients department. We found that these were checked on the 3rd of August 2015 for the ear nose and throat (ENT) equipment, treatment room one and miscellaneous items.However, treatment room two had no documented checks since the 20th of July 2015.
- On further observation in treatment room one we found that there were a number of sterile instruments, Hudson masks, needles and three way taps out of date. We raised this with staff at the time of our inspection, and wewere informed this treatment room was not used routinely. When we inspected treatment room two we found dust on two manual sphygmomanometers, and out of date dressings, biopsy needles, suture material, and sonic gels. We also found vaginal pessary drains which did not have a use by date on them. We also found ointments that did not have an opened date or use by date on them. We asked staff about them and they were unable to identify where they came from, we raised this with a manager at our inspection and all items were removed.
- During the subsequent unannounced visit to the department we inspected both treatment rooms again, and found the cleanliness of the rooms had improved. However, the cleaning and checking schedules remained incomplete. We also checked stocks and found small applicators which were out of date.
- Following our unannounced inspection we received assurances from the hospital including a performance improvement plan and supporting documents which had been shared with staff detailing how stocks would be appropriately maintained in the future.
- We saw staff adhering to the hospital's bare below the elbows policy.
- Staff wore protective aprons and most wore gloves when required and regularly used hand gel between patients
- Hand washing signage was clearly displayed and sufficient supplies of hand gel, hand soap and paper towels were available throughout the department.
- The outpatient and diagnostic imaging departments were part of the hospital wide infection control audits and spot checks which monitored compliance with key hospital policies such as hand hygiene. Outpatients and diagnostic imaging demonstrated 96% compliance with infection control procedures during June and July 2015

Diagnostic Imaging

- Clinical and non-clinical areas were visibly clean, well maintained and tidy.
- There were bottles of hand gel throughout the department and regularly used by staff and patients. There was adequate signage promoting hand washing in the unit and toilet areas.
- Clear and detailed cleaning instructions had been provided to staff for the cleaning of CT and MRI scanning areas to ensure hygiene, maintain staff safety and to protect the equipment.
- We saw staff adhere to the bare below the elbows policy.
- Cleaning audits were routinely undertaken and were up-to-date at the time of inspection.
- Clinical waste disposed of appropriately in clinical waste bags.

Environment and equipment

Outpatients

- The environment in outpatient areas appeared uncluttered, and well maintained.
- Appropriate containers for disposal of clinical waste and sharps were available and in use across all departments.
- Staff we spoke with stated they had sufficient equipment to meet the needs of patients.
- We looked at equipment and refrigeration and found these were appropriately checked, cleaned and maintained. We found that Portable appliance testing (PAT) and calibration stickers were missing on fridges and scales, however, we reviewed evidence which identified these were all up to date.

Outpatients and diagnostic imaging

- Records showed resuscitation equipment and defibrillation machines were checked daily in the outpatient department.
- Physiotherapy had a fully equipped gym for rehabilitation and therapeutic regimes.
- We noted the endoscopy unit had a compliant bacterial and protein sampling history. Tracking of the decontamination cycle, personnel and patient association of each endoscope was completed using manual systems.

Diagnostic imaging

- The environment was uncluttered, spacious and free from trip hazards.
- We looked at equipment and refrigeration and found these were appropriately checked, cleaned and maintained.
- Portable appliance testing (PAT) and service logs were up to date and monitored by the hospital engineer.
- Maintenance contracts and service level agreements were in place with external providers to service, maintain and repair equipment. X-ray equipment maintenance contracts were checked and records showed all schedules were up to date. Staff told us requests for service and repairs were met quickly and effectively by all contractors.
- CT scanner was 12 months old and the MRI scanner 3 years old. Both had a full service history.
- Records showed resuscitation equipment and defibrillation machines were checked daily in the Diagnostic Imaging department.
- Restricted access areas were locked appropriately and signage clearly indicated if a room / scanner was in use. The department had radiological protection/hazard signage displayed.
- The hospital had policies and procedures in place in relation to principle radiation and protection regulations. These included principle radiation legislation, radiation proection advisor report, local rules and description of the duities to be undertaken by staff in accordance with legislation.
- Due to the locking system in the MRI suite, two staff members always worked together to ensure safety and wellbeing given the magnetic strength from the MRI when in use.
- Staff felt they were provided with appropriate protective equipment to undertake their role safely, wearing lead aprons as required.
- Stock rotation is undertaken twice weekly.

Medicines

Outpatients

- Medicines including local anaesthetic and contrast media were supplied and audited by the pharmacist. Audits demonstrated high levels of compliance.
- Anaphylaxis, epilepsy, eye wash and extraction boxes were made up by the pharmacy department. We reviewed records which showed monthly checks had been completed.
- Safe temperatures for fridges were recorded including maximum and minimum temperatures. The fridge was kept locked at all times.
- Outpatients did not use group directives (PGD).

Diagnostic Imaging

- Stock was topped up twice a week. There were 2 emergency drugs cases, one in CT and one in the main x-ray.
- Pharmacy completed audits of all medication for out of date drugs. Staff check fridge temperatures which were all signed and dated at the time of the inspection. One was in progress during inspection.
- Radiologists or Clinical Consultants prescribe and administer medication. Radiographers prepared it for administration.
- We found that senior managers had overall responsibility for medications in the department and staff would refer or report to them if any issues arose.
- No Nuclear medication radiation was performed held at Spire Washington and as a result there are no HAZMAT arrangements in place.

Records

Outpatients

- At the time of inspection we saw patient personal information and medical records were managed safely and securely.
- We looked at the medical records of nine patients attending outpatient and physiotherapy clinics. We found these were of a good standard. They contained sufficient up to date information about patients including referral letters, medical and nursing notes, operation and anaesthetic records and discharge documentation. However, three of the physiotherapy records did not document the time of the review.

Outpatients and diagnostic imaging

- Discharge and clinic letters were dictated by the consultant then typed up and sent faxed to the patient's general practitioner. The longest time we saw between clinic and letter being sent was three days.
- There were no patients seen without full medical records being available.
- Staff we spoke with in outpatients, radiology and physiotherapy could not recall an instance were medical records had not been available for a clinic, or where a patient could not be seen because their records were not available. This was because patient records were stored on the hospital site.
- The hospital had a policy that consultants should not take patient medical records out of the hospital. If a consultant took patient identifiable data out of the hospital in the form of tapes or electronic dictation, the consultant must take adequate steps to protect the information and be registered with the Information Commissioner 's Office (ICO) on the register of Data Controllers. All consultants are requested to register with ICO when they apply for practising privileges. Review of practising privilege agreements confirmed this.
- Electronic patient records and images were encrypted and password protected, as are images captured on disc.
- Record keeping had recently been audited between April 2015 and July 2015 in the physiotherapy department. This quarter one audit showed 76% compliance. Common themes were identified as patient experiences was not documented (≥50%), lack of identification of subjective markers and were not reviewed, and no risk assessments which resulted in no action being taken. Action plans were in place to ensure improvements were made.

Diagnostic Imaging

- No records were held in the Diagnostic Imaging Department. All referrals received were actioned and the images returned by registered post to the referring hospital. This was followed up by a report sent separately. At the time of inspection we saw patient personal information and medical referrals were managed safely and securely.

Safeguarding

Outpatients

- The hospital had safeguarding policies and guidance in place for both children and adults.
- Safeguarding training was mandatory for all staff. The training rate was 100% for level 1 vulnerable adults training and 100% for level 1 safeguarding children.
- All staff we spoke with were aware of safeguarding policies and guidance and could describe how to report and escalate a safeguarding issue. The name and photo of the adult and child safeguarding lead was clearly visible in the department
- All staff had access to a simple flowchart to aid with decision making and reporting concerns regarding vulnerable adults.

Diagnostic imaging

- The Diagnostic Imaging department had safeguarding policies and guidance in place for both children and adults.
- Safeguarding training was mandatory for all staff on the department. The training rate was 100% for Safeguarding level 1 Vulnerable Adults and Children, 85% of staff had completed Safeguarding Children Level 2 and one Team Lead had completed Safeguarding Level 3 Vulnerable Adults and Children.
- Both staff members we spoke with were aware of safeguarding policies and guidance and could describe how to report and escalate a safeguarding issue.
- All staff had access to a simple flowchart to aid with decision making and reporting concerns regarding vulnerable adults.

Mandatory training

Outpatients

- We were informed that mandatory training needs were identified yearly and each staff member receives a corporate training booklet to complete.
- Staff reported mandatory training was delivered by a combination of face to face training and eLearning. Staff we spoke with said that should it be required, equipment representatives would attend the department to update staff or provide training on new equipment. They reported both they and their line manager received automatic electronic alerts from the Clinical Governance team when training was due. All staff were given sufficient time to complete mandatory training.

Outpatients and diagnostic imaging

- We found annual training modules undertaken by staff included Fire Safety at work (82% completed), Health and Safety (74%), Infection control (68%), Compassion in practice (58%), Safeguarding Refresher Courses (58%). Manual handling (61%) courses were undertaken bi-annually. Courses that were undertaken once only included vulnerable adults (100%) and safeguarding children (97%), Equality and Diversity (97%). Role dependant training modules included managing violence and aggression (97%), Datix incident reporting (1%) and mental capacity act training (76%). These rates were year to date at the time of the inspection. The hospital has a 95% target for all training modules by the end of the calendar year.
- Medical staff completed mandatory training at their main employing NHS trust. There were assurance systems in place to make sure that medical staffs were up to date with mandatory training.

Diagnostic imaging

- Staff reported mandatory training was delivered by a combination of face to face training and eLearning.
- We found annual training modules undertaken by radiology staff include Fire Safety at Work (70% completed), Health and Safety (65%), Infection Control (65%), Compassion in Practice (70%) and Safeguarding Refresher Courses (68%). Manual Handling Courses (75%) are undertaken bi-annually and courses undertaken once include Child Protection (100%), Equality and Diversity (100%) and the Protection of Vulnerable Adults (100%). These rates were year to date at the time of the inspection. The hospital has a 95% target for all training modules by the end of the calendar year.
- Role dependant training includes Managing Violence and Aggression (95%), Datix Incident Reporting (10%) and the Mental Capacity Act (65%).
- We found staff felt well supported in relation to participating in training opportunities, both internal and external. They stated that there was always opportunity for professional growth and that they were encouraged to further their careers.

Assessing and responding to patient risk

Outpatients & Diagnostic Imaging

- There was a process in place for managing patients who were deteriorating. This included firstly contacting the resident medical officer (RMO), involving the patient's consultant and transferring the patient to the Accident and Emergency department of the local NHS hospital. Staff were aware of their roles and responsibilities when patients deteriorated, Staff we spoke with stated they felt empowered to contact consultants directly if a patient was deteriorating.
- There were emergency assistance call bells in all patient areas including consultation rooms, treatment rooms and x- ray. Staff confirmed when used they were answered immediately.
- The Endoscopy unit had undergone the Joint Advisory Group (JAG) accreditation process and was awarded accreditation.
- There were plocies policies and procedures in place in the diagnostic imaging department to ensure that risks to patients from exposure to harmful substances were managed and minimised.

Nursing staffing

Outpatients

- The outpatient department had a dedicated team of registered nurses, healthcare assistants, medical laboratory assistants, pharmacist's physiotherapists, radiologists, receptionists and administration staff.
- Staffing levels were based on the number of patients expected to attend and number, type and complexity of clinics to be held however there was no specific acuity tool used. The department was able to use staff flexibly to meet patient needs. We were advised that new staff had been recruited and are due to start shortly
- Staff and patients we spoke with, and our observations confirmed there was enough staff available to meet patient's needs.
- There were no vacancies within the nursing and health care assistant staff in the outpatient department at the time of inspection. A total of 7.7 whole time equivalent (WTE) nurses 2.7 WTE health care assistants (HCA's) were employed. Bank staff were used in clinics on occasion to cover holidays, sickness and expected busy times. The hospital used its own bank staff that worked at the hospital regularly and were familiar with the organisation, policies and procedures.

Outpatients and diagnostic imaging

- There were systems and processes in place to request additional temporary staffing and the service used temporary nursing, physiotherapy and radiography staff when shortages were identified

Diagnostic Imaging

- The Diagnostic Imaging department staffing consisted of 1 Diagnostic Imaging Manager (37.5 hours), 4 MRI / CT Radiographers, 1.7 Radiographers, 0.95 Mammographer, 1 Assistance Practitioner, 0.5 radiology administrator, 3 x-ray administrators, 2 bank CT radiographers, 1 bank MRI radiographer, 1 bank HCA, 2 bank Mammographers and 1 banks radiographic practitioner assistants.

Medical staffing

Outpatients

- The hospital out sourced RMO cover to the research fellows at Newcastle University and Locum RMO cover was sourced from NES Healthcare. The RMO provision covered the hospital 24 hours a day seven days a week. They were present to manage emergency situations.
- The hospital held a spread sheet of all consultant contact details and this was accessible to all staff, the on call rota was circulated throughout the department so that staff were aware of who to contact.
- There were 162 consultant doctors and dentists employed by surrounding NHS trusts that had practicing privileges to run clinics, carry out treatment and procedures and operate at this hospital.
- We spoke with three consultants and all stated that the hospitals was sufficiently flexible to accommodate doctors preferred consulting times in outpatients.

Diagnostic Imaging

- 13 Consultant Radiologists held practicing privileges to work in the Diagnostic Imaging Department.

Major incident awareness and training

Outpatient & Diagnostic Imaging

- There was a hospital major incident policy and staff were aware of contingency plans should major incidents occur. As an independent provider the Spire Washington Hospital would not routinely become involved in major incidents external to the organisation.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Services provided by the outpatient and diagnostic imaging department were effective. Care and treatment was evidence based and patient outcomes were measured and within acceptable limits.

Staff in the department were competent, and there was evidence of multidisciplinary working. Although the service did not operate a full seven day service, the outpatient and diagnostic imaging departments had extended opening hours and support services such as physiotherapy. An On-call service was also provided 24hrs per day, 7 days per week.

Evidence based care and treatment

Outpatients

- Departments were adhering to local and Spire Healthcare corporate policies and procedures. Staff were aware of how policies and procedures had an impact on patient care. For example, physiotherapy was following NICE guidance in relation to acupuncture and consultant led protocols regarding post-operative physiotherapy and rehabilitation.
- Staff from the outpatient department, physiotherapy, pharmacy and endoscopy told us they took part in local audits,for example, infection control and documentation. All of these audits either demonstrated compliance or identified action to take to improve practice, for example the physiotherapy department had identified areas for improvement in record keeping and had an action plan in place to improve standards. Safety alerts were received by the department managers and all relevant alerts were emailed to all staff, displayed in the staff office and discussed at team meetings.
- Physiotherapists held exercise classes and undertook reflective discussion around what went well and what could have been improved or what they may have done differently. Reflection on practice had informed changes to exercise classes for patients suffering from back pain as well as physiotherapists considering a wider range of treatments or interventions for individual patients.

Outpatients and diagnostic imaging

Diagnostic Imaging

- Local and National Spire Hospital policies were in accordance with Radiology Protection Association (RPA) and Ionising Radiation (Medical Exposure) Regulations IR(ME)R guidance and requirements.
- Peer audits of clinical recording were undertaken and overseen by the Governance Manager; information was shared with staff and action plans created to drive quality improvement. Outcomes showed areas of weakness in relation to the overuse of abbreviations and failure to sign request forms.
- Future planned audits include Image quality, referral proforma quality and Radiographer compliance.
- Staff explained that prompt feedback is available for patients due to all images being digital. It was felt that this facility and technology streamlined the process for patients.

Pain relief

Outpatients

- There was a process in place to enable patients attending the outpatient department to access pain medication. Pain medication was dispensed via a personalised prescription by the pharmacy. At times when the pharmacy was closed staff were able to access medication.
- Pharmacists had 1:1 consultations with patients whilst on the ward to discuss their take home medications prior to discharge, including pain medication.

Diagnostic Imaging

- Medicines for pain relief such as lignocaine for local anaesthetic, saline and contrast media were stored in locked drugs cupboards in two general radiology rooms and in the MRI suite. The Radiographer was able to explain the procedure for checking and stock control. All medicines checked were in date.
- No controlled drugs were used in the department.

Patient outcomes

Outpatients

- From April 2014 to March 2015 the hospital outpatient department saw 32,539 patients. Of these, 11,465 were new appointments and 21,074 were review appointments. The hospital saw 14,112 NHS appointments and 18,427 private patient appointments.
- Patient outcomes in physiotherapy were monitored by well recognised outcome measures such as range of movement, pain scores and quality of life measures to establish effectiveness of treatment. Distances walked and numbers of repetitions were also used as measures of improvement where appropriate.

Diagnostic Imaging

- From April 2014 to March 2015 the diagnostic imaging department saw 19,849 patients. Of these, the average time in days between the appointment request and the appointment taking place was 8.29 days. There is no breakdown available to determine how many patients were new appointments, review appointments of private patient appointments.
- Reported times in the diagnostic imaging department have shown that the average waiting time from scan to report for routine tests is 3.5 days and 1 day for urgent scans.

Competent staff

Outpatients

- Managers told us formal arrangements were in place for induction of new staff and all staff, including bank and agency staff, completed full local induction and training before commencing their role.
- Staff told us they were encouraged to undertake continuous professional development and were given opportunities to develop their clinical skills and knowledge through training relevant to their role.
- Staff received a formal annual appraisal and mid-term appraisal every six months. We reviewed an appraisal compliance audit that confirmed 92% of staff had undergone an annual appraisal; those which had not been carried out were due to maternity and unplanned leave.
- Appraisals were linked to the hospital vision and values and the Spire strategy. Staff told us their objectives were set at appraisal and learning needs and further training was discussed and planned.
- Medical appraisal was carried out at the main employing NHS trust for consultants with practicing privileges 98% of these were up to date. There was a process in place to ensure all consultants were up to date with the revalidation process.

Diagnostic imaging

Outpatients and diagnostic imaging

- Managers told us formal arrangements were in place for induction of new staff and all staff, including bank staff, completed full local induction and training before commencing their role.
- Managers and staff told us performance and practice was continually assessed through appraisal and mid-year reviews. Reviews were carried out once per year. Staff we spoke with confirmed they received regular appraisals and mid-year reviews. The appraisal rate for Diagnostic Imaging staff was 71% end of year 2014. The mid-year review 2014 rate was 86%
- Staff confirmed they were encouraged to consider and undertake continuous professional development and were given opportunities to develop their clinical skills and knowledge through training relevant to their role.
- Staff felt confident and comfortable with the knowledge and skills held and maintained by their colleagues.

Multidisciplinary working (related to this core service)

Outpatients

- A range of clinical and non-clinical staff worked within the outpatients department and told us they all worked well together as a team.
- Staff were observed working in partnership with a range of staff from other teams and disciplines including: radiographers, physiotherapists, nurses, booking staff, and consultant surgeons. Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.
- There were clear agreed protocols for staff to follow and where patient care deviated outside of these, nursing, radiology, laboratory and physiotherapy staff told us they were able to easily access consultants and specialist staff. For example the hospital leads for safeguarding to discuss required interventions.

Diagnostic Imaging

- Two of the clinical and one non-clinical staff member working within the diagnostic imaging department told us they all worked well together as a team.
- Staff in the department were observed working in partnership with other members of staff from other teams and disciplines including nurses, administrators, and consultant Radiologists. Staff members were observed to be respectful towards the time pressures and skill mix of others.

Seven-day services

Outpatients

- The main outpatient service operated a six day week Monday to Thursday 8am to 9pm, Friday 8am to 8pm service and Saturday 08.30am until 1pm
- Physiotherapy operated a six day week Monday, Tuesday, Thursday 07.30am to 8pm Wednesday 08.00 to 8pm, Friday 07.30 to 7pm and Saturday 08.00 to 12.00.
- Pathology services were provided on site 9am-5pm Monday to Friday

Diagnostic Imaging

- Radiographer cover was provided 24 hours a day and seven days per week with full departmental cover between the hours of 8am to 8pm Mondays to Friday, 8am to 12pm on Saturdays to meet the needs of a new CT service.
- 1 Registered Medical Officer (RMO) is on duty in the hospital 24hrs 7 days per week covering all areas of the hospital.

Access to information

Outpatients

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning. Paper copies of local policies were also kept in a folder at the outpatient reception area.
- The endoscopy suite had standard information folders based on each work area for example the inpatient wards and outpatient desk, should a patient telephone the hospital with a concern when the Endoscopy unit was closed. This meant that staff could give the appropriate information and reduce the risk of conflicting advice.
- Staff were able to access patient information such as x-rays electronically and paper medical records and separate physiotherapy records appropriately.

Diagnostic Imaging

- All diagnostic imaging staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as x-rays and medical records appropriately, through electronic and paper records.

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients

- Senior staff reported that within the outpatients department implied consent was obtained from the patient before any care and treatment interventions, such as obtaining specimens, routine diagnostic tests and the checking of height, weight and basic physiological signs. Staff reported if consent could not be safely obtained or the patient lacked capacity to consent, they would contact the hospital safeguarding lead for advice. There was a process in place for staff to follow when patients were not able to give consent because they had fluctuating capacity.
- We reviewed six sets of physiotherapy records and all documented consent had been obtained prior to treatment commencing.
- We spoke with staff about their understanding of consent, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS). Although staff had an understanding of consent they had limited understanding of the MCA and DOLS as very few patients lacked capacity. The key contact details of the lead for MCA and DOLS were visible to staff contact if required.

Diagnostic imaging

- Staff we spoke with had completed some training with regard to the Mental Capacity Act and Deprivation of Liberty Safeguards. We found varied levels of understanding in relation to the implications on their role and responsibilities should results from a patient's assessment show a lack of mental capacity. Most staff could not explain when an assessment might be indicated, how it would be requested or who would complete it.

Are outpatients and diagnostic imaging services caring?

Good

During the inspection we saw and were told by patients that staff in the outpatient, diagnostic imaging and physiotherapy departments were caring and compassionate. Patients and relatives commented positively about the care provided from all of the outpatient and physiotherapy staff.

The oncology service supported a peer support group for the women undergoing treatment at the hospital, they organised motivational speakers and trips out together.

People were treated courteously and respectfully and their privacy was maintained. Services were in place to emotionally support patients. Patients were kept up to date with and involved in discussing and planning their treatment. Patients were able to make informed decisions about the treatment they received.

Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions or treatment.

Compassionate care

Outpatients

- All patients we spoke with in the outpatient clinics spoke highly of the care and treatment they received. There were no negative comments about the compassionate and caring aspects of the service.
- During our inspection we saw patients being treated respectfully by all staff. We also saw occasions when staff noticed that patients were nervous and reassured them. We saw patient's privacy was respected and they were addressed and treated respectfully by all disciplines of staff.
- Staff were observed to knock on doors before entering and curtains were drawn and doors closed when patients were in treatment areas and consulting rooms.
- We saw patients and staff had a good rapport with staff putting patients at ease. Some patients were regular attenders and knew the staff well. New patients also confirmed they were put at ease and felt staff were caring towards them.
- Patients were offered the use of a chaperone for intimate examinations.
- We spoke to nine patients who gave very positive accounts of their experiences with staff and the processes followed.
- Patients are provided with 'Please talk to us' leaflets. These were visible in the main clinical areas. These detail how patients can raise concerns.

Outpatients and diagnostic imaging

Diagnostic Imaging

- We found there was a private waiting area with private cubicles for patients to change into the necessary clothing.
- Doors were closed when patients were in scanning / x-ray areas. The environment in the Scanning rooms allowed for confidential conversations.
- We saw patients and staff had a good rapport and staff put patients at ease.
- Flexibility was offered around appointments and where possible appointments were altered to meet the needs of patients.
- It was highlighted that free of charge SMS appointment reminder service is available for patients.
- 'Please talks to us' leaflets were provided to patients so they had an opportunity to report their findings or concerns to the hospital.
- Friends and Family test highlighted that in May 99% and in June 100% of patients were extremely likely or likely to recommend Spire Washington Hospital.

Understanding and involvement of patients and those close to them

Outpatients and Diagnostic Imaging

- We observed staff spending time to explain procedures to patients before gaining written consent. For example, in endoscopy ,staff were seen and heard to explain to patients what to expect when procedures were carried out.
- Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their treatment.
- All of the patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about the care and treatment they could have. They all confirmed they were given time to make decisions and staff had made sure they understood the treatment options available to them.
- We were told of a support group set up by the oncology suite to involve women in the development of the service and provide motivational speakers. Staff we spoke with informed us that the women in the group went out to purchase furnishings for the suite.
- Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their treatment.

Emotional support

Outpatients

- We saw staff spend time talking to patients and showing empathy and encouragement to complete aspects of therapy.
- Staff were aware of the emotional impact of pain on patient well-being and this was an integral part of quality of life measures used in physiotherapy to assess and evaluate clinical improvements and effectiveness of treatment.
- Staff were able to give examples of when they had talked to worried patients, for example, when a patient had complained of discomfort during the dressing of a sinus, and also how they had to care for a child with learning difficulties. Staff recounted how they supported the patient and child.

Diagnostic imaging

- Radiology had a part-time healthcare assistant who acts as chaperone and provides additional care and emotional support to patients during interventional procedures such as biopsies and angiograms.
- For patients who are distressed or very anxious e.g. suspected breast malignancy, the oncology nurse specialist stays with them in a quiet treatment room and brings the patient direct to the interventional room when it is prepared, thus avoiding waiting in public areas.
- All staff including radiologists, clinical consultants, radiographers, HCA, talked to patients and aimed to reassure them during any procedure. Inform them of what will happen and is happening to them, engage with the patient.

Are outpatients and diagnostic imaging services responsive?

Good

Outpatient and diagnostic imaging services were responsive to the needs of patients. Patients were able to be seen quickly for urgent appointments, and clinics were only rarely cancelled at short notice. Provision was made to for children in the waiting area, however, signage to advise parents they were responsible for their children was not placed in full view of the waiting area.

Outpatients and diagnostic imaging

Mechanisms were in place to ensure the service was able to meet the individual needs of people such as those living with dementia, a learning disability or physical disability, or those whose first language was not English.

Systems were in place to capture concerns and complaints raised within the department, review these and take action to improve the experience of patients.

Service planning and delivery to meet the needs of local people

Outpatients

- Staff and patients told us clinics seldom ran late however there was no data collected by the hospital about this. Clinics were monitored on a daily basis in real time to ensure waiting time are kept to a minimum, however, this data is not recorded.
- Clinics tended to run in a predictable pattern and the busier time periods were staffed accordingly.
- Staff told us clinics were only rarely cancelled with short notice, but that clinics were occasionally cancelled with notice to fit in with the NHS commitments of consultants. We received data that the hospital received 70 notifications regarding clinics of these 58% were cancelled clinics in July 2015. The primary reason for these notifications were consultants being on annual leave and consultant commitments at NHS trust (39). We were not provided with data previous to the system had recently begun collated electronically.

Diagnostic Imaging

- Most patients who used the department, whether as a private patient or an NHS patient were referred by their GP.
- There was capacity within the department to see patients urgently if necessary.
- We found a new CT service being promoted which covered weekends to provide flexibility for patients. Appointments are arranged with patients so that the most suitable time can be agreed

Access and flow

Outpatients

- Between April 2014 and March 2015 the hospital met the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month. With the exception of May 2014 when it was 99%, the remaining months achieved 100%.
- The waiting time for patients varied depending on whether they were NHS or private patients. We reviewed data that identified the average waiting time for outpatient appointments between April 2014 and March 2015 was 13.5 days. NHS patients waited an average of 19 days and 8 days for private patients.
- The hospital collected limited data about 'Did not attend' (DNA) rates. The DNA rate for all outpatient appointments was 4.5%.
- Patients were observed to be seen on time in the majority of cases however the hospital did not collect information about how long patients were waiting to be seen once they arrived. Most patients who used the hospital, whether as a private patient or an NHS patient were referred by their GP.
- Physiotherapy services were accessible for all as patients did not all require private medical insurance to be reviewed in the department. Patients were able to self-refer or be referred by their GP or Consultant.

Diagnostic Imaging

- The hospital collected 'Did not attend' (DNA) rates for all appointments and found that 19, 849 patients attended and 256 (1%) did not attend appointments from April 2014 to March 2015.
- Radiology offered late appointments five days a week and on a Saturday morning to meet the needs of the local population.
- Mechanisms were in place to ensure the service was able to meet the individual needs of people such as those with mobility, Mental Health and Learning Difficulties. There was good access for wheelchairs and adequate seating for patients who required support from family, friends and carers when attending appointments.

Meeting people's individual needs

Outpatients

- Staff told us they were able to access interpreting and translation services if they needed to. However, staff we spoke with identified this was rarely required.

Outpatients and diagnostic imaging

- A range of information leaflets were available, which provided patients with details about their clinical condition and treatment or surgical intervention. We saw staff used these leaflets as supportive literature to reinforce their physiotherapy treatment and exercise regimes.
- Some patient information leaflets were available in large print for patients with visual impairment. Patient information was not available in alternative languages but staff explained they would ensure the patient fully understood what they needed to, before they left the department.
- Staff told us when patients with learning disabilities or dementia attended the departments; they allowed carers to remain with the patient if this was what the patient wanted. They also ensured that patients were seen quickly to minimise the possibility of distress to them.
- Staff we spoke with gave us examples of how patients attending the department on a stretcher were taken straight in to consulting rooms and made comfortable.
- Information signage was adequate within outpatients and patients appeared to be able to make their way around both departments easily.
- There was not a specific area for children in the waiting area, however, a sign was visible advising parents to speak to reception where a box of toys was available, and these were cleaned after each use.There were hot and cold refreshments available in the waiting area and patients were asked not to remove hot drinks from this area. There was signage present to ask parents to supervise their children whilst in the department; however, this was displayed in the main reception area next to the door leading through to the Out patients Department. It was not openly displayed within the waiting area itself.
- The patient waiting area was tidy with sufficient comfortable seating for patients visiting the department. There was access to drinks and books and magazines for patients who were waiting.
- There were toilet facilities available for patients including toilets with disabled access within the hospital. The oncology suite did not have a toilet within it meaning women undergoing chemotherapy would have to use the main outpatient department toilets.
- There were separate male and female changing rooms for the endoscopy suite,and following a JAG inspection a retractable blind was installed to protect patient's dignity as they walked into theatre.
- The environment was clean with a relaxed atmosphere. Patients were able to help themselves to drinks and magazines prior to their appointment.
- Spire Washington provided patients with access to free television Wi-Fi connections and free car parking during their hospital visit.

Diagnostic imaging

- When a patient requires a translation service to aid their understanding of their care and treatment this would be provided by a telephone translation service. Where necessary face to face translators could be arranged.
- Patient waiting areas were tidy with sufficient comfortable seating for patients visiting the department. There was access to a drinks machine, books and magazines for patients who were waiting.

Learning from complaints and concerns

Outpatients

- The hospital reported 24 formal complaints between April 2014 and March 2015 for outpatient areas. The main themes included the attitude of consultants and communication errors.
- Staff described how they would resolve patient's concerns informally in the first instance, but would escalate to senior staff if necessary.
- Staff were aware of the formal complaints process and policy as well as the mechanisms for the reporting, investigation and feedback to departments.
- Complaints and comments were reviewed and discussed by teams at monthly staff meetings. We saw minutes of meetings which reflected this.
- We saw examples of learning from complaints.

Diagnostic Imaging

- The hospital reported three formal complaints from October 2014 to March 2015 for the Radiology department.
- All attempts were made to resolve complaints informally in the first instance, but they would be escalated to senior staff if necessary. The three complaints highlighted all reached a satisfactory outcome and were dealt with on an informal basis.

Outpatients and diagnostic imaging

- Staff discussed their knowledge of the formal complaints process , policy, and the mechanisms for reporting, investigation and feedback to departments.
- The Governance Lead discussed complaints with department leads and Patient Outcomes Officer action plans were developed and lessons learned were shared at clinical meetings. The main themes were interdepartmental issues which were discussed in governance meetings.

Are outpatients and diagnostic imaging services well-led?

Good

The outpatient and diagnostic imaging department was well-led. Staff and managers had a vision for the future of the department and were aware of the risks and challenges they faced. Staff felt supported and were able to develop to improve their practice. There was an open and supportive culture where incidents and complaints were reported, lessons learned and practice changed. The department supported staff who wanted to be innovative and try new services and treatments.

The hospital engaged with staff and patients were given opportunities to provide feedback about their experiences of the services provided and staff regularly engaged with patients waiting for appointments.

Staff in all outpatient areas stated they were well supported by their managers. They were visible and provided clear leadership. Staff and managers told us there was an open culture. They felt empowered to express their opinions and felt they were listened to.

Vision, strategy, innovation and sustainability and strategy for this this core service

Outpatients

- The senior management identified a vision for the future of services. They were aware of the challenges faced by the departments and were developing action plans in to address them. For example, checking of and cleaning of treatment rooms and staffing.
- Staff were aware of the Spire corporate vision and strategy and were seen to display the behaviours expected of them.
- The organisational, local and departmental vision, strategy, goals and objectives were incorporated into the individual objectives of staff through the appraisal process.

Diagnostic Imaging

- The senior management demonstrated clear ideas for the future of department. They were aware of the challenges previously faced by the team and were eager to provide consistency and direction.
- The Spire vision and strategy were incorporated into the individual objectives of staff through the appraisal process.

Governance, risk management and quality measurement for this core service

Outpatients

- Governance arrangements were in place, which staff were aware of and participated in. The hospital had regular clinical governance meetings and team meetings.
- Staff were given feedback about incidents and lessons learned, comments, compliments and complaints. Audits and quality improvement were also discussed.
- The hospital had a risk register in place and managers updated this accordingly. Managers were aware of the risks within their departments and were managing them appropriately. For example, physiotherapy, phlebotomy and radiology had identified risks associated with IT and equipment failure. Staff were able to clearly articulate contingency plans in place should equipment failure occur.
- There were good links to the medical advisory committee (MAC), we reviewed evidence that concerns with consultants were found to be escalated appropriately and discussed and actions taken as appropriate.
- The service managers described how there were audit systems in place to measure the quality and accuracy of work carried out within the departments.

Diagnostic imaging

- Governance arrangements were in place, which staff were aware of and participated in. The trust had regular

clinical governance meetings and team meetings which were undertaken twice per week. Any data changes to risk assessment or changes to policy and procedure where discussed at these meetings
- Staff stated they were given feedback about incidents and lessons learned comments, compliments and complaints. Audits and quality improvement were also discussed.
- The hospital had a risk register in place and managers updated this accordingly. Managers were aware of the risks within their departments and were managing them appropriately. For example, staff were able to clearly articulate contingency plans in place should equipment failure occur.
- Staff we spoke with OR senior management described audit systems in place to maintain and improve clinical practice including risk assessing.
- Detailed risk assessments were held by senior managers were easily accessible by all staff. Risk assessments in place included (but not limited to) assessment of general health and safety, assessment of pregnant staff member, electromagnetic fields, exposure to radiofrequency and excessive noise. Each assessment noted the level of risk, action taken to reduce the risk and a date when the risk should be reviewed. All risk assessments were up to date.
- Annual radiation meetings held with the Radiation Protection Advisor (RPA) and Radiation Protection Supervisor (RPS) which are recorded. The RPA is based at the Freeman Hospital, Newcastle but had good relationships with the staff at Spire Washington. The RPS is a consultant Radiographer based on site.
- The last RPA report was completed in December 2014 and concluded that "Spire Washington continues to demonstrate a very high awareness of radiation protection issues and compliance with legislation is generally very good".

Leadership/culture of service

Outpatients

- The department manager was appointed in March 2015 as it was recognised there was a lack of leadership and direction in the department. There were clear lines of management responsibility and accountability within the outpatient's department.
- Staff in all areas stated they were well supported by their managers. They were visible and provided clear leadership. Staff felt that managers communicated well with them and kept them informed about the running of the departments and relevant service changes.
- Staff told us they would be confident to raise a concern with their managers if they needed to and felt listened to and engaged in the organisation.Staff told us that leadership from the hospital director and other managers was very open and honest. Managers were seen on a daily basis in departments throughout the hospital by all staff. Managers were known on first name terms,were approachable, encouraging questions and suggestions from all staff.

Diagnostic imaging

- We found several line management changes since 2013 following the resignation of a Manager in October 2013. There was then appointment of an interim manager in January 2014 to Sept 2014, followed by a manager from Sept 2014 to February 2015 and finally the appointment of the current Manager in July 2015. There were systems and processes in place to support the diagnostic imaging team during these periods change. Most clinical supervision and appraisals were undertaken by the Head of Clinical Services.
- There were clear lines of management responsibility and accountability within the diagnostic imaging departments. Regardless of the previous senior management changes staff stated they continued to feel supported in their role by other senior managers. Staff in all areas stated they were well supported by their line manager who provided clear leadership.
- Staff felt that managers communicated well with them and kept them informed about the running of the department and relevant service or department changes.
- Staff told us they would be confident to raise a concern with their managers if they needed to and felt listened to and engaged in the organisation.
- Staff told us that leadership from managers was very open and honest.
- Managers were seen on a daily basis in departments throughout the hospital by all staff. Managers were known on first name terms and were approachable.
- The senior management told us they felt supported in their role and they could escalate any concerns via simple and effective procedures.

Outpatients and diagnostic imaging

Culture within the service

Outpatients

- Staff and managers told us the outpatient department had an open culture. They felt empowered to express their opinions and felt they were listened to.
- Staff told us they were all encouraged to report concerns, record incidents and take part in team meetings. They all felt that these would be investigated fairly. They told us managers were open to comments and suggestions for improvements from staff, for example staff in the physiotherapy department had developed a process to improve appoints.
- Staff were encouraged to "take responsibility and to make decisions". They felt supported to do this every day.
- Managers said they felt well supported by senior management and the organisation.
- All staff we spoke with were proud to work for the Spire Washington Hospital.

Diagnostic Imaging

- Staff and managers told us the diagnostic imaging department had an open culture. They felt able to highlight any concerns and were confident any necessary actions would be taken.
- Staff felt supported but also felt able to work autonomously and believed their clinical judgement was respected.
- Staff showed awareness of the corporate ethos and culture. High levels of staff morale were observed and staff stated that there was a strong work ethic between colleagues of all grades. All staff we talked to spoke highly of Spire Washington Hospital.
- No whistleblowing concerns were received.

Public and staff engagement

Outpatients

- The hospital actively sought patient feedback. Staff regularly spoke with patients waiting for appointments to gather their feedback. Feedback was discussed at team meetings. For example patients in the oncology suite identified that a toilet within the unit would improve their time spent there, one patient noted that it was not pleasant to walk to the toilet with the cold cap in situ.
- The hospital has a continuous cycle of patient surveys as well as taking part in the friends and family test. We reviewed the results that showed 99% of patients were either likely or extremely like to recommend the Spire Washington Hospital to friends and family.
- We spoke with three consultants during our inspection, we were told that the hospital was able to accommodate consulting times and nursing support was appropriate.

Diagnostic imaging

- Telephone etiquette training had been undertaken by 81% of all contracted staff since June 2015
- Friends and Family test highlighted that in May 99% and in June 100% of patients were extremely likely or likely to recommend Spire Washington Hospital.
- Staff in the department received verbatim comments from patients each month by email from senior management. We were informed that the negative comments are addressed by the Patient Outcome Manager.

Innovation, improvement and sustainability

Outpatients

- Staff were encouraged to suggest ways to make departments run more effectively and efficiently.
- Physiotherapists were due to start a pink ribbon exercise group for ladies attending the oncology suite. This group was developed using feedback from staff and patients.
- Physiotherapy staff developed a “chitty” to improve the follow-up appointment process. They were supported by line manager. Staff we spoke with confirmed that this innovation had improved the care patients received in the department
- The hospital offered an appointment reminder service. This was a free service where patients were reminded about their appointment by text message.

Diagnostic imaging

- A new CT service is currently being introduced which will operate on Saturday mornings. This is actively being promoted at the present time to provide alternative appointments to patients on a Saturday.

Termination of pregnancy

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Spire Washington Hospital provided support, information, treatment and aftercare for women seeking termination of pregnancy. The service was part of the main outpatient and inpatient service, with outpatients offering consulting rooms, ultrasound scanning equipment, pharmacy, pathology and nursing staff to support patients throughout the consultation process, a ward with single occupancy en-suite rooms and a fully staffed and equipped operating theatre suite which included a dedicated recovery area with two high dependency beds for more complex patient needs.

The Hospital held a licence from the Department of Health to undertake termination of pregnancy procedures. The licence was displayed at the hospital entrance.

Women were involved in their care and encouraged to make an informed choice on the method of abortion to be carried out. Most surgical abortions were carried out on women of early gestations (between six and eight weeks). Medical abortions were carried out on women of all gestations within the legal limits and there were two women who required overnight stays and both had longer gestations (between 13 and 16 weeks). 10 patients had undergone surgical abortion and 12 patients had undergone medical abortion in the 12 month period prior to our inspection.

Women aged under 18 years were not treated at Spire Washington Hospital. Any women requiring these services who were under this age limit were referred to British Pregnancy Advisory Service(BPAS) or NHS providers.

There were specific staff dedicated to care for patients who required termination of pregnancy services. We spoke with these staff including three registered nurses and a consultant gynaecologist.

We looked at the care records of 20 women. We were unable to observe care or treatment or speak to any women since there were no patients for termination of pregnancy in the hospital for the duration of our inspection.

Termination of pregnancy

Summary of findings

Termination of pregnancy services were safe, caring, effective, responsive and well led.

The ward area staff complied with best practice with regard to cleanliness and infection control. Incidents and risks were reported and managed appropriately and lessons learned and actions to be taken were cascaded to front line staff. Staff were aware of procedures to be followed in the case of a major incident.

Nursing and medical staffing was sufficient and appropriate to meet the needs of patients in their care. Medicines were stored and prescribed safely. However, medical abortion records did not always show clearly who had administered misoprostol tablets. Medical records were legible and assessments were comprehensive and complete, with associated action plans and dates.

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Patient outcomes were monitored. Pain relief was prescribed pre and post-procedure and women were reassessed for pain following both types of abortion. Medical records were complete and written consent was obtained in all cases.Staff were trained and assessed competent for general nursing practice. However, they had no specific formal training or competency assessments to ensure they were able to meet the needs of the women who required termination of pregnancy services. Informal training had been provided by appropriate consultant staff.

There were no women attending out patients or the ward for consultation, procedures or advice during any of the days of our inspection. We were therefore unable to observe the way patients were treated by staff.

Staff told us how they involved and treated women with compassion, kindness, dignity and respect. The results of the Friends and Family test demonstrated that 98% of all patients at Spire Washington Hospital were 'extremely likely' or 'likely' to recommend the service to family and friends.

The service was responsive to the needs of women. Pre and post-procedure checks and tests were carried out at the hospital and waiting times were consistently within the guidelines set by the Department of Health. Interpreting and counselling services were available to all women and the hospital was accessible for those with disabilities. Information and advice were available to women at all stages of their episode of care and foetal remains were disposed of sensitively, although staff were unaware that women should be able to choose how this happened.Women were offered testing for sexually transmitted infections prior to any treatment but this was not consistent. There had been no complaints from women accessing the hospital for termination of pregnancy but there were robust and effective systems in place for managing complaints should they arise.

Senior managers had a clear vision and strategy for this service. There was strong local leadership of the service and quality care and patient experience was seen as all the staff's responsibility.

Staff felt proud of the service they provided and felt that they met the requirements of Department of Health (DH) Required Standard Operating Procedures and Royal College of Gynaecologists Clinical Guidelines. They felt supported to carry out their roles and were confident to raise concerns with managers.

Termination of pregnancy

Are termination of pregnancy services safe?

Good

Termination of pregnancy services were safe. The ward area staff complied with best practice with regard to cleanliness and infection control. Incidents and risks were reported and managed appropriately and lessons learned and actions to be taken were cascaded to front line staff. Staff were aware of procedures to be followed in the case of a major incident.

Nursing and medical staffing was sufficient and appropriate to meet the needs of patients in their care. Hospital cleanliness audit results and safety thermometer results were at or almost at 100%. Medicines were stored and prescribed safely. However, medical abortion records did not always show clearly who had administered misoprostol tablets.

We reviewed 20 patient records who had received termination of pregnancy services in the previous year.All were written legibly and assessments were comprehensive and complete, with associated action plans and dates. All Department of Health documentation was completed according to protocols. Staff were able to demonstrate their understanding of safeguarding adults and children and could describe actions to be taken in cases of suspected abuse.

Incidents

- There was an electronic system for reporting incidents. Staff were encouraged to report incidents and received feedback on the incidents they had reported. All staff we spoke with were familiar with how to report incidents.
- There had been no incidents in the previous 12 months relating to termination of pregnancy patients or procedures.
- Governance meetings were held every Monday of each week. Datix information was shared and discussed and relevant risk assessments were updated. The learning and actions were cascaded to clinical staff at local team meetings.
- Risk registers were evident within the surgical ward and were up to date and relevant.
- Every member of staff we spoke with was of and understood the principles of the Duty of Candour. Staff stated that they were provided with awareness training through management meetings.

Cleanliness, infection control and hygiene

- All wards, clinical and non-clinical areas were clean and we saw staff wash their hands and use hand gel between patients. Staff adhered to the bare below the elbow policy.
- Separate hand washing basins, hand wash and sanitizer was available on the wards, theatre and patient areas.
- Staff complied with best practice with regard to infection prevention and control policies. All nursing staff adhered with the bare below the elbow policy to enable good hand washing and reduce the risk of infection. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. Staff washed or applied hand gel to their hands between treating patients.
- There was clear Infection control information and this was displayed throughout the hospital.
- All elective patients undergoing surgery who met the hospitals screening criteria were screened for Methicillin resistant Staphylococcus aureus (MRSA) and procedures were in place to isolate patients when appropriate in accordance with infection control policies. There were no reported cases of Clostridium Difficile, MRSA or Meticillin-sensitive Staphylococcus aureus (MSSA) during the 12 months prior to our inspection.
- Standards of cleanliness were monitored and an annual plan showing all infection control audits displayed recent data figures. Infection control audits were completed every month and monitored compliance with key organisational policies such as hand hygiene. Recent audits showed compliance with hand hygiene protocols varied from 49% to 100% on the ward. We discussed the low compliance on one area of the ward with the ward sister. The cause of this (staff using a shared corridor for access) had been identified and processes put in place to ensure improvement.
- Theatre and recovery areas were visited and found to be clean, well organised and subject to regular comprehensive audits.
- No patients undergoing surgical termination of pregnancy had an infection following their procedure.
- Spire, Washington Hospital had an infection control annual audit plan to monitor and control infection and

to maintain a clean and appropriate environment. The plan included current compliance of the whole organisation against different standards of infection control and required actions where issues were identified. Staff training and audits were undertaken at Spire hospitals.
- PLACE audits rated the hospital as 100% for cleanliness with the national average being 97% in 2014.

Safety thermometer

- The hospital used the NHS Safety Thermometer which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Performance was monitored by the senior management team and communicated to the wards and departments.
- The National Safety Thermometer audits were a CQUIN (Commissioning for Quality and Innovation) compliance target for its Standard acute NHS contract.
- Safety thermometer information included information about all new harms, falls with harm, urinary tract infections and new pressure ulcers and was displayed on boards in both wards and theatre areas.
- Between April 2014 and March 2015 safety thermometer information showed no urinary tract infections and that risk assessments were being appropriately completed for all patients on admission to the hospital.

Environment and equipment

- Emergency equipment checks were up to date and fully completed. Resuscitation equipment was available in case of an emergency and was checked daily to ensure that the correct equipment was available and fit to use. Single-use items were sealed and in date, and emergency equipment had been serviced.
- The ward comprised of single use rooms with en-suite bathroom facilities, suction equipment, piped oxygen and emergency call facilities.
- There was adequate, clean equipment to ensure safe patient care and all portable appliance testing (PAT) of electrical equipment had been carried out and labels were clearly evident and in date.
- The hospital adhered to the management of clinical waste's policy specifically for the disposal of foetal remains. Patients were provided with an information sheet which laid out how the remains would be managed. In all cases foetal remains were stored securely, collected and transported to the pathology department at a neighbouring NHS hospital before being sent for respectful cremation.
- No women had expressed an interest in disposing of foetal remains themselves but staff told us that this could be accommodated and remains collected from the pathology department.

Medicines

- There was an established system for the management of medicines to ensure they were safe to use. This included clear monitoring of the stock levels, stock rotation and the expiry dates of medicines. The minimum and maximum temperatures of fridges where medication was stored was monitored daily to ensure that medication was stored at the correct temperature. There were appropriate lockable storage facilities for medicines in all areas.
- Single rooms offered separate lockable facilities to store patients own medicines. There was a clear policy evidenced for the self-administration of medicines.
- Controlled drug records were checked and medication record administration forms and found to be clear, concise and fully completed.
- The hospital pharmacy was well organised and managed. We observed that pharmacists ensured that each patient was visited prior to discharge to ensure that they had a full understanding of the medicines that they were prescribed.
- Women were asked if they had any known allergies and it was clearly recorded in the pre-assessment forms.
- Following a face to face consultation with a consultant gynaecologist, the doctor would prescribe the required medication after making sure that the HSA1 form was signed by two medical practitioners and the woman understood the procedure and had given written consent. Drugs that induced abortion were prescribed only by a doctor for women undergoing medical abortion.
- All medicines for women undergoing medical or surgical abortion were prescribed by a doctor. Medicines were administered by doctors until after the first administration of misoprostol for subsequent doses, qualified nurses could administer tablets prescribed by the doctor. However, records did not always show clearly who had administered the second set of tablets onwards.

- Post-surgical antibiotics were prescribed and administered to all women to reduce the risk of infection.
- Medication error audits had been carried out and results showed that there had been no administration or documentation errors relating to patients undergoing termination of pregnancy procedures.

Records

- Patient records were paper based. Patient information and records were stored safety and securely in lockable cabinets in line with the data protection act.
- Department of Health registers were completed clearly, accurately and in a timely way and stored securely.
- White boards displaying clinical activity for each day maintained patient confidentiality.
- Care pathways were used and completed clearly in all records that were checked.
- Staff completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. All records we looked at were completed accurately. There was comprehensive pre-operative health screening questionnaire and assessment pathway.
- Record keeping and documentation audits were carried out and compliance was consistently good.
- Patient records were well maintained and well completed with clear dates, times and designation of the person documenting. We reviewed 20 patient records. These records were written legibly and assessments were comprehensive and complete, with associated action plans and dates.
- Comprehensive pre-operative assessments were undertaken and recorded where women underwent surgical abortion.
- In the medical records we checked, all gestations were 16 weeks or below prior to termination. All HSA1 forms had two appropriate signatures; one from the consultant carrying out the procedure and the second from either the patient's GP or another consultant carrying out terminations at this hospital. .
- The Department of Health (DH) required every provider undertaking termination of pregnancy to submit demographical data following every termination of pregnancy procedure performed (HSA4 form). We observed this data was recorded in the medical records at the initial consultation.

Safeguarding

- Safeguarding policies were clearly visible on the ward and accessible for staff.
- Staff when asked were clearly able to demonstrate their understanding of the policy and could describe actions to be taken in cases of suspected abuse. Staff were aware of the safeguarding policies and principles within the hospital.
- Data relating to training levels in safeguarding for the whole staff team evidenced the following:
  - Safeguarding adults Level 1: 89%. Level 2 or above: 55%
  - Safeguarding children Level 1: 88% Level 3 17% (safeguarding lead).
- The Head of Clinical Services for Spire, Washington Hospital was the designated safeguarding lead. Staff knew who the safeguarding lead for the service was and where to seek advice.
- All staff we spoke with had received training about safeguarding children and adults. They were clear about their responsibilities and how to report concerns.

Mandatory training

- Data provided showed that staff were clearly supported to maintain mandatory training requirements.
- All staff we spoke to felt that they were encouraged with their professional development and allowed time to complete mandatory training.
- Ward staff told us they were up to date with their mandatory training. completed and arranged mandatory training was 100% for valuing people and respecting differences, 100% for MCA training, 100% for risk assessments training, 89% for safeguarding adults and 89% for infection control. These rates were year to date at the time of the inspection. The hospital has a 95% target for all training modules by the end of the calendar year.

Assessing and responding to patient risk

- All patients were risk assessed at the point of admission and (national early warning score) NEWS scores were performed at all nursing observations.
- We evidenced clear patient pathways in termination of pregnancy services which included escalation policies for the deteriorating patient. Nursing staff had good access to medical support in the event a patient's condition might deteriorate. If the consultant

gynaecologist was not available on site they could be contacted at any time by telephone and would return to the hospital as quickly as possible. If a patient required urgent medical attention the staff could call upon the resident medical officer (RMO) who were available on site 24 hours a day, seven days a week. There were emergency transfer arrangements in place to local NHS hospitals should they be required.

- Staff told us that they had access to consultants in person or by telephone but could call upon the services of the resident medical officer if they need to at any time.
- Prior to termination procedures all women should have a blood test to identify their blood group. It was important that any patient who has a rhesus negative blood group receives treatment with an injection of anti-D. This treatment protects against complications should the patient have future pregnancies. The records that we reviewed demonstrated that all the women underwent a blood test prior to the termination procedure and those who had a rhesus negative blood group would receive an anti-D injection.
- Most women, but not all, underwent an ultra sound scan to determine gestation of the pregnancy. This differed between patients and consultant gynaecologists only scanned women if gestation was questionable.
- Pregnancy testing was carried out at the initial consultation to confirm a pregnancy. The hospital policy was for all women of childbearing age to have a pregnancy test before undergoing any interventional procedure and at the last audit the compliance rate had been 100%.
- During surgical procedures, staff used the 'Five Steps to Safer Surgery' iniaitive, which is designed to prevent avoidable mistakes. These were completed appropriately in the patient records we reviewed.

Nursing staffing

- Nursing staff rotas were evidenced and a staffing level tool was used in accordance with patient dependency and risk. Staffing ratios were adjusted according to the nature and number of patients attending on any given day.
- A daily assessment of nursing staff requirement was undertaken to ensure the nursing needs of patients were met throughout the full 24hr period as recommended by NICE guidelines. Staff worked flexible shifts to allow for changes such as late theatre lists.
- Staffing levels of both qualified and healthcare workers for each part of the 24hr period appeared to accurately reflect the needs of the patients we saw.
- There was one full time (day shifts) and two part time (night shift) registered nurses in the regular ward team who could be called upon for advice.
- We saw clear effective handovers.
- The hospital recently trailed the Shelford safe staffing tool as part of a Spire project, which is currently being reviewed corporately.
- There was no use of agency qualified staff on the wards.

Medical staffing

- Consultants accepting women for termination of pregnancy procedures were responsible for the full episode of their care and booked admissions appropriately to ensure they would be available for the time required to care appropriately until their discharge. Staff told us that consultants were always available and accessible when they needed support.
- The hospital held information electronically which was accessible to all staff and outlined consultant cover and cross cover arrangements. The consultant handbook stated that all consultants must arrange suitable cross cover from a 'suitably skilled' colleague, with practising privileges for periods that they were unable to attend the hospital. The hospital's resident medical officers were on site 24/7 and department heads were issued with 'on call' rotas.

Major incident awareness and training

- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience and response
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency and staff we spoke to were aware of the procedure for managing major incidents.

Termination of pregnancy

Are termination of pregnancy services effective?

Good

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Patient outcomes were monitored. Pain relief was prescribed pre and post-procedure and women were reassessed for pain following both types of abortion. Medical records were complete and written consent was obtained in all cases.

Staff were trained and assessed competent for general nursing practice. However, they had no specific formal training or competency assessments to ensure they were able to meet the needs of the women who required termination of pregnancy services. Informal training had been provided by appropriate consultant staff.

Evidence-based care and treatment

- All consultants adhered to the Royal College of Obstetricians and Gynaecology (RCOG) guidelines, The Abortion Act and abortion legislation for the treatment of women for termination of pregnancy. Women with special conditions such as foetal anomaly and ectopic pregnancy were not treated at the hospital but referred to local NHS providers.
- Policies were accessible for staff and were developed in line with Department of Health Required Standard Operating Procedures (RSOP) relating to termination of pregnancy and professional guidance.
- Staff followed a local work instruction for termination of pregnancy that included standard operating procedures specific to Spire Washington Hospital and best practice (following RSOPs and Royal College of Gynaecologists (RCOG) clinical guidelines for medical and surgical abortions.

Pain relief

- Pre and post procedural pain relief was prescribed on all medication records.
- Following medical abortions the nursing staff would ask the patient about pain during nursing observations. If further pain relief was required then the consultant gynaecologist would be asked to reassess the patient. If they were unavailable then nursing staff would call the RMO to assess the patient.
- Following surgical abortion, the anaesthetist visited patients on the ward to check pain levels and prescribe further pain relief as necessary. Patients were not discharged without a full assessment by the consultant.

Patient outcomes

- All patients who underwent medical abortion had a two day gap period from the first tablet to the second tablet and the time elapsed between patient outpatient consultations and commencement of treatment for a medical procedure was 0- 3 days. This was compliant with the DOH guidelines. (RSOP11).
- For surgical abortions the time elapsed from outpatient appointment to surgical procedure ranged from 0-5 working days. This was compliant with DOH guidelines which stated "women are offered the abortion procedure within 5 working days of the decision to proceed and the total time from access to procedures should not exceed 10 days".
- No patients who had surgical terminations of pregnancy in the 12 months prior to our inspection required a return to theatre.
- A Termination of pregnancy audit had been carried out in October 2014 to ensure compliance with the Department of Health's (DOH) code of practice for abortion under the Abortion Act 1967(as amended in May 2014). The hospital had audited all records of women undergoing terminations of pregnancy. A total of 19 patient records were audited and compliance with Required Standard Operating Procedures (RSOPs) had been variable. There had been some gaps and omissions in documentation but also some non-compliance in practice for instance not all women were tested for or offered screening for sexually transmitted infections (STI) and this was not compliant with DOH guidelines (RSOP 12/13). Three records did not have second doctor signatures and auditors had been unable to ascertain if contraception had been discussed with seven patients (RSOP 12). Psychological needs of each patient were not reviewed or recorded for six patients by the nursing staff (care pathway)

Termination of pregnancy

- An action plan had been drawn up and all staff informed of non-compliance issues. Monitoring of the action plan was in progress and most of the actions had been completed.

Competent staff

- Staff told us they had regular annual appraisals Information provided by Spire Washington Hospital showed that 100% of appropriate staff had completed an appraisal in the time period April 2014 to March 2015.
- All the staff were supported through an induction process and competence based training relevant to their general nursing role. Nursing staff had completed compassion training. However staff had no access to specific formal training or competency assessments to ensure they were able to meet the needs of the women they delivered care to. For example, there were no competencies recorded for administration of tablets or pessaries via a vaginal (PV) route.
- Staff said informal training had been provided by appropriate consultant staff.
- The hospital recorded 100% validation for doctors working under practicing privileges.
- In line with Spire Healthcare Policy Clinical 17, Medical Appraisal, a framework for appraisal was based on Good Medical Practice, which was used to inform the education, training and practice of all doctors in the UK. The hospital ensured that every doctor, with practising privileges, was supported with appraisal that promoted their professional development and reflected any regulatory and professional requirement. The Hospital Director was responsible for managing any performance concerns relating to a consultant's practice. There had been no concerns relating to the medical practice of any of the doctors carrying out terminations of pregnancy.

Multidisciplinary working (related to this core service)

- Medical staff, nursing staff and other non-clinical staff worked well together as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care. However, although consultants prescribed misoprostol tablets for the second dose onwards, it was not always clear who had administered the medication to the patient.
- The staff told us that they had close links with other agencies and services such as the local safeguarding team and all consultants had substantive NHS posts at the local hospitals where good practice was shared.
- Spire Washington Hospital had service level agreements with neighbouring NHS Trusts which allowed them to transfer a patient to the hospitals in case of medical or surgical emergency.

Seven-day services

- Most terminations of pregnancy procedures were carried out as day procedures at Spire Washington Hospital. Two patients, both had medical terminations of between 13 and 16 weeks' gestation had overnight stays.
- Terminations were carried out at the patients' convenience and although surgical procedures were carried out on weekdays, some medical abortions took place at weekends.
- The Required Standard Operating Procedures set by the Department of Health set out that women should have access to a 24-hour advice line which specialises in post abortion support and care. The ward staff at Spire Washington Hospital provided a 24 hours per day and seven days a week service. Callers to the Spire Washington Hospital could speak to registered nurses who would give advice. This team of nurses had received no formal training for this role from Spire Washington Hospital.

Access to information

- Staff had access to relevant guidelines, policies and procedures in relation to termination of pregnancy services.
- Department of Health registers were completed for every termination procedure carried out and these were stored securely on the ward.
- Staff at the hospital ensured that patient care records were made available to consultants and ward staff in a timely and accessible way and in line with Spire Washington Hospital protocols. Records were stored on site for 3 months before being transferred to a national record storage centre where they could be retrieved within 24 hours if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All care records we reviewed contained signed consent from women. Possible side effects and complications were recorded and the records showed that these had been explained to women.

Termination of pregnancy

- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DOLs). While there were no specific examples to support the implementation of their responsibilities under the Act staff discussed the need to ensure that women had capacity to make an informed decision. They also identified the need to act in the person's best interest, seeking advice and making joint decisions with others if there were concerns about a person's capacity to understand.
- There was access to guidance and policies for staff to refer to in regard to Mental Capacity Act (MCA) and Deprivation of liberty safeguards (DoLS).
- Staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), records provided (June2015) showed 75% staff compliance with this training.

Are termination of pregnancy services caring?

Good

There were no women attending out patients or the ward for consultation, procedures or advice during any of the days of our inspection. We were therefore unable to observe the way patients were treated by staff. However, we spoke with staff, reviewed patient feedback and information, and reviewed appropriate records during our visit.

Staff told us how they involved and treated women with compassion, kindness, dignity and respect. The results of the Friends and Family test demonstrated that 98% of all patients at Spire Washington Hospital were 'extremely likely' or 'likely' to recommend the service to family and friends.

Staff explained the different methods and options available for abortion. If women needed time to make a decision, this was supported by the staff. All the women considering termination of pregnancy had access to pre-termination counselling. Post- termination counselling was provided if required.

Compassionate care

- There were no women attending out patients or the ward for consultation, procedures or advice during any of the days of our inspection. We were therefore unable to observe the way patients were treated by staff.
- Staff told us how they involved and treated women with compassion, kindness, dignity and respect.
- Staff told us that women's preferences for sharing information with their partner or family members were established, respected and reviewed throughout their care. Younger women were encouraged to involve their parents or family members and their wishes were respected. No women under the age of 18 had consultations or underwent procedures for termination of pregnancy at Spire Washington Hospital.
- The results of the Friends and Family test demonstrated that 98% of patients at Spire Washington Hospital were 'extremely likely' or 'likely' to recommend the service to family and friends.

Understanding and involvement of patients and those close to them

- We were unable to observe the initial assessment .Medical staff told us they explained all the available methods for termination of pregnancy that were appropriate and safe to women. The consultant would consider gestational age and other clinical needs whilst suggesting these options.
- Women could request a chaperone to be present during consultations and examinations. However, the outpatients staff told us that a nurse would usually offer to be present during the consultation.
- The records we reviewed recorded the post discharge support available for women and those close to them. Women were given written information about accessing the ward in the 24 hours following their procedure.
- We asked staff if there were occasions when women changed their minds about terminating their pregnancy. We were told that this had not happened to date but occasionally women would telephone to find out the cost of the procedure and might decide not to proceed. There were other services available with no costs to the patient in local NHS hospitals.
- Staff told us that women were made aware of the statutory requirements of the HSA4 forms and were reassured that the data published by the DH for statistical purposes was anonymised.

Emotional support

Termination of pregnancy

- All women were offered a counselling service prior to the treatment. This service was also available post termination procedure if required. Patients were given counselling information in the form of a leaflet with names and contact numbers of one private counsellor as well as the local BPAS counsellor. Nursing staff told us that they would answer any queries or invite patients to return to the ward in the 24 hours following a termination procedure. Details of professional pregnancy and termination counsellors were given to women at their initial consultation.

Are termination of pregnancy services responsive?

Good

Spire Washington Hospital provided services to suite the needs of women. Pre and post-procedure checks and tests were carried out at the hospital and waiting times were consistently within the guidelines set by the Department of Health.

Interpreting and counselling services were available to all women and the hospital was accessible for those with disabilities. Information and advice were available to women at all stages of their episode of care and pregnancy remains were disposed of sensitively, although staff were unaware that women should be able to choose how this happened.

Women were offered testing for sexually transmitted infections prior to any treatment but this was not consistent. We found no positive test results for women treated at the hospital in the 12 months prior to our inspection but staff told us that women with positive test results would be referred to local sexual health services for further screening and treatment as appropriate.

There had been no complaints from women accessing the hospital for termination of pregnancy but there were robust and effective systems in place for managing complaints should they arise. The organisation was able to show how changes had been made in response to patient complaints.

Service planning and delivery to meet the needs of local people

- Women could book their appointments through the Spire Washington Hospital appointments system. The consultant gynaecologists provided appointments throughout the week and women were able to access the most suitable appointment for their needs and as early as possible.
- Spire Washington Hospital was able to offer contact information for other Spire hospitals if a woman preferred a different location. If women did not want to pay for their procedure or fees were prohibitive then staff could signpost them to local NHS hospitals

Access and flow

- Most women were either referred by their GP or self-referred and then attended their GP who signed the HSA1 form as the second signatory. Women were asked if they wanted their GP to be informed by letter about the care and treatment they received. Women's decisions were recorded and their wishes were respected.
- The hospital undertook all aspects of pre-assessment care including pregnancy testing, counselling, date checking scans to confirm pregnancy and to determine gestational age and other pre-termination assessments such as STI tests.
- Spire Washington Hospital monitored the average number of days women waited from initial contact to consultation, from consultation to treatment and the whole pathway from contact to treatment.
- Department of Health Required Standard Operating Procedures state that women should be offered an appointment within five working days of referral and they should be offered the abortion procedure within five working days of the decision to proceed. The service monitored its performance against the waiting time guidelines set by the Department of Health.At Spire Washington Hospital no women waited longer than the recommended time of five working days from referral to consultation and none waited longer than five working days from decision to proceed to termination of pregnancy.
- Women who had undergone a surgical procedure were offered a follow up appointment but medical staff told us that women did not tend to routinely take up this option.

Meeting people's individual needs

Termination of pregnancy

- The hospital was accessible to wheelchairs users and disabled toilets were available.
- A professional interpreter service was available to enable staff to communicate with women for whom English was not their first language. There were also staff within the hospital who spoke other languages fluently and agreed to be called upon if patients preferred to speak to someone face to face. Staff told us that they could also use the interpreter service to ensure the patient understood and could weigh up the decision to continue the treatment.
- Staff told us that support was available for women with a learning disability or other complex needs.
- Spire Washington Hospital treated fit and healthy women without an unstable medical condition. Women who did not meet these criteria would be referred to the most appropriate NHS provider to ensure that they received the treatment they required in a timely and safe way.
- Women were given information leaflets at the first consultation about different options available for termination of pregnancy including what to expect when undergoing a surgical or medical termination. These also included any potential risks, counselling services and sensitive disposal of foetal remains. Women were told that foetal remains would be disposed of sensitively but staff had not treated any women who expressed wishes around how the remains were disposed of or who had beliefs against cremation.
- We did not observe any consultations or discussions with women regarding terminations of pregnancy, during our inspection.
- Nurses and medical staff undertaking pre-surgical assessments had a range of information available to them that they could give to women as required. This included advice on contraception, sexually transmitted infections and services to support women who were victims of domestic violence and how to access sexual health clinics.
- Leaflets were given to women to inform them what to expect in the 24 hours following the procedure. This included the ward direct line telephone number that women could ring to seek any advice if they were worried.
- Contraceptive options were discussed with women at the initial assessments contraception following the abortion was discussed. The women were provided with information on contraceptive options and devices. These included Long Acting Reversible methods (LARC) which are considered to be most effective as suggested by the National Collaborating Centre for Women's and Children's Health. We saw evidence that IUCDs had been inserted immediately following two surgical abortions.
- RCOG guidance 'the care of women requesting induced abortion' suggests that information about the prevention of sexually transmitted infections (STI) should be made available. It also suggests that all methods of contraception should be discussed with women at the initial assessment and a plan should be agreed for contraception after the abortion. Women were offered testing for sexually transmitted infections prior to any treatment but this was not consistent. We found no positive test results for women treated at the hospital in the 12 months prior to our inspection but staff told us that women with positive test results would be referred to local sexual health services for further screening and treatment as appropriate.
- There was no evidence to show that discussions were held with women regarding the disposal arrangements for pregnancy remains or that women's wishes were respected and their beliefs and faith were taken into consideration. Spire Washington Hospital had not recorded whether women had specific wishes about burial or sensitive disposal of pregnancy remains and staff were not aware that women could make their own choices. Staff told us that most women did not want to know about disposal of pregnancy remains. However they did provide all women with a leaflet from the local NHS trust that managed the process, giving specific information about how all pregnancy remains would be cremated sensitively. It also provided information about NHS Trust memorial services.
- Staff were unaware of any arrangements for women who wished to dispose of the pregnancy remains privately in accordance with HumanTissue Authority (HTA) Guidance on the disposal of pregnancy remains following pregnancy loss or termination.

Learning from complaints and concerns

- No women who had undergone procedures for termination of pregnancy had made complaints about staff or the service at Spire Washington Hospital in the 12 months prior to our inspection. Complaints in general were logged, dealt with quickly and sensitively by staff in outpatients and on the ward and written complaints were entered onto the hospital incident

reporting Datix system. The complaints process was robust with any, themes or trends identified being reviewed by the clinical governance lead, medical advisory committee and senior management team. Any actions , outcomes and lessons learned were shared with clinical teams and all departments.

- Staff told us that patients were given an opportunity to raise concerns with any staff member whilst at the hospital. Staff felt empowered to attempt to resolve situations where appropriate. "Please talk to us" leaflets were readily available in clinical areas and reception which detailed how patients could raise concerns. Patients are also able to email Spire Healthcare customer service desk via the Spire website, in order to raise concerns.

Are termination of pregnancy services well-led?

Good

Senior managers had a clear vision and strategy for this service and staff were able to repeat this vision and discuss its meaning with us during individual interviews. There was strong local leadership of the service and quality care and patient experience was seen as all the staff's responsibility.

Staff felt proud of the service they provided and felt that they met the requirements of Department of Health (DH) Required Standard Operating Procedures and Royal College of Gynaecologists Clinical Guidelines. They felt supported to carry out their roles and were confident to raise concerns with managers.

Clinical governance was well managed and DH documentation had been completed and submitted correctly. Comments, concerns and complaints were shared with staff and examples of how the organisation had learned from them were displayed.

Vision, strategy, innovation and sustainability and strategy for this this core service

- The organisation's mission was "to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care. We constantly invest in our people, facilities and equipment to ensure our patients receive a high standard of care". The organisation had clearly defined corporate objectives to support its aim.
- Staff believed they provided a high quality service to women who chose to have their termination of pregnancy procedure at Spire Washington Hospital.
- Staff were aware that fewer women chose to use the services at Spire Washington Hospital because terminations of pregnancy were offered and easily available at local NHS hospitals.
- Spire Washington Hospital had a Department of Health Certificate of Approval that was displayed at the entrance to the hospital.

Governance, risk management and quality measurement for this core service

- There were monthly health and safety meetings and quarterly risk committee meetings, both of which fed into the Senior Management meeting. At each meeting they reviewed complaints, incidents, serious incidents, audit results, complications, patient satisfaction and quality assurance. We saw records that showed detailed information was shared with a focus on shared learning.
- Medicines and Healthcare products Regulatory Agency (MHRA) Alerts and Safety Notices were processed by Spire corporately and emailed to Spire Washington Hospital clinical governance team for action by the Clinical Governance Lead.
- The hospital had a risk register which included various areas of risk identified. These risks were documented and a record of the action being taken to reduce the level of risk was maintained.
- The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for the termination and sign a form to indicate their agreement (HSA1 Form). We looked at 20 patient records and found that all forms included two signatures and the reason for the termination. In most cases the GP would provide the second signature but when the patient preferred not to involve their GP this would be provided by another consultant gynaecologist at Spire Washington Hospital.
- Spire Washington Hospital had completed a termination of pregnancy audit which included HSA1 forms to ensure and evidence with Department of Health compliance. Spire Washington Hospital's last audit was carried out in October 2014 had demonstrated that 5

out of 13 HSA 1 forms did not have a second signature. However, this had been addressed and all forms in patient records we looked at from the 12 months prior to our inspection had 2 signatures present.

- The Department of Health (DH) required every provider undertaking termination of pregnancy to submit demographical data following every termination of pregnancy procedure performed. These contribute to national report on the termination of pregnancy (HSA4 forms).The HSA4 forms were signed by the consultant gynaecologist who performed the procedure and sent to the Chief Medical Officer within 14 days of the procedure.

Leadership/culture of service

- The staff at Spire Washington Hospital felt well supported by managers and told us they could raise concerns with them. Staff told us the senior management were available and had a regular presence on their departments. They also said the consultants were approachable and helpful.
- The service maintained a register of women undergoing a termination of pregnancy, which is a requirement of regulation 20 of the Care Quality Commission (Registration) Regulations 2009. This was completed in respect of each person at the time the termination was undertaken and was retained for a period of not less than three years beginning on the date of the last entry. The registers were kept securely in a locked drawer on the ward and made available to us throughout our inspection.
- The certificate of approval for carrying out termination of pregnancy (issued by the Department of Health) was displayed at the hospital entrance.

Culture within the service

- Staff displayed an enthusiastic, compassionate and caring manner regarding the care they delivered. They recognised that it was a difficult decision for women to seek and undergo a termination of pregnancy.
- Staff spoke positively about the high quality care and services they provided for women and were proud to work for Spire Washington Hospital. They described Spire Washington Hospital as a good place to work and as having an open culture.
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents. Staff felt they could openly approach managers if they felt the need to seek advice and support.

Public and staff engagement

- Women attending the hospital were not asked to provide feedback specific to their procedure and experience due to the sensitivity of the procedure and the emotional experience for the women but the Friends and Family Test results for Spire Washington Hospital were 85% of all patients gave positive responses in the 12 month period prior to our inspection and 98% of outpatients responded positively the month before the inspection.
- Staff on the ward and in the outpatients department received verbatim comments from patients each month by email from senior management. Any negative comments were addressed by the Patient Outcome Manager.
- Medical staff told us that the hospital were able to accommodate their needs in treating patients to the RCOG standards.

Innovation, improvement and sustainability

- Consultant gynaecologists provided the service and used skills and experience gained in their NHS posts.
- Consultants worked with ward and theatre staff and surgeons to secure sufficient time and staff were available to ensure the patient experienced the best care possible. Consultants worked weekends where necessary to ensure patients could have their procedure at a time that was convenient for them and to meet Department of Health guidelines.

Outstanding practice and areas for improvement

Outstanding practice

- Patient forums were held for patients who had undergone endoscopy procedures.
- A breast cancer support group meets regularly and monitors the outcomes of patients who have undergone treatment for breast cancer.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital SHOULD take to improve

- Continue to monitor cleaning schedules and checks for expired equipment to ensure that they are completed correctly, particularly in the outpatient department.
- Review staff's understanding of Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS), particularly in the outpatient and diagnostic imaging departments .
- Ensure that all medication records show the name and role of the person administering medicines used for medical abortion.
- Ensure that nursing staff have appropriate formal training and competencies to care for women requiring termination of pregnancy.
- Ensure that all women undergoing termination of pregnancy are allowed to make choices with regard to their wishes and beliefs regarding sensitive and respectful disposal of pregnancy remains.
- Ensure staff are made aware that women might choose to dispose of pregnancy remains themselves and of the processes to enable this.